Statewide Health Care Insurance Plan Task Force

Final Report

December 2001

FINAL REPORT

STATEWIDE HEALTH CARE INSURANCE PLAN TASK FORCE

December 2001

Membership

Senator Edward Cirillo
Co-Chair

Senator John Verkamp
Senator Virgina Yrun
Mr. Terry Cooper
Dr. George Burdick

Representative Jim Carruthers
Co-Chair

Representative Linda Binder
Representative Robert Cannell
Representative Tom O'Halleran
Mr. Erin Collins

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SECTION 1. INTRODUCTION

This final report summarizes the efforts of the Statewide Health Care Insurance Plan Task Force (Task Force) during the past year. The report is divided into four sections. In addition to an overview of the report format, this introductory section provides background information regarding the purpose of the Task Force and its membership. This section is followed by Section 2, which contains a general overview of the Task Force activities and accomplishments. Section 3 sets forth the specific Task Force findings and recommendations. Lastly, Section 4 contains copies of all the handouts that were distributed at the Task Force meetings.

As required by the legislation this report is being submitted to the Arizona Speaker of the House of Representatives, the Arizona President of the Senate and the Governor for their review and consideration.

Purpose of Task Force

The Task Force, which was established pursuant to Laws 2000, Chapter 320, was charged with the task of developing an affordable and accessible health care insurance plan for all Arizonans. As part of this effort the Task Force was also required to undertake the following activities:

- Identify and assess potential insurance risk pools among residents of this State.
- Study and recommend timely and efficient reimbursement methods.
- Determine benefit levels.
- Review current national, state and local public health care plans.
- Review and analyze the role of state agencies and political subdivisions under a statewide health care insurance plan.
- Analyze health care insurance factors that vary among urban and rural areas and recommend ways in which these factors could be streamlined.
- Study and recommend ways to treat rural and urban areas in an equitable manner.
- Identify the various sources of monies to fund a statewide health care insurance plan.
- Explore alternatives that may be used to initiate a health care plan that would be available to and affordable for residents in both rural and urban areas.

Task Force Membership

As set forth in the legislation, the Task Force consisted of nine members: three members of the House of Representatives, three members of the Senate and three public members who are appointed by the Governor and who represent a health care provider, a consumer advocacy group and the business community. The following members were initially appointed in August 2000:

- Senator Cirillo, Co-Chair
- Senator Bee

- Senator Richardson
- Representative Carruthers, Co-Chair
- Representative Blewster
- Representative Nichols
- Dr. George Burdick
- Mr. Erin Collins
- Mr. Terry Cooper

While five of the committee members, i.e., co-chairs and public members, remained the same throughout the duration of the Task Force's existence, due to changes in the make-up at the Legislature, the following legislative members were appointed in the spring of 2001:

- Senator Yrun
- Senator Verkamp
- Representative Binder
- Representative Cannell
- Representative O'Halleran (ex-officio)

Pursuant to the legislation, the Task Force is repealed from and after December 31, 2001.

SECTION 2. TASK FORCE ACTIVITIES

Prior to formalizing its recommendations, the Task Force devoted a great deal of its time to educating themselves about health care coverage in Arizona, issues surrounding the accessibility and affordability of coverage and strategies that have been implemented in other states to address these issues. Along with this education process, the Task Force members spent time discussing the issue and possible solutions.

The Task Force was supported in their efforts by the $1.16 million State Planning Grant that the AHCCCS Administration (AHCCCSA) received from the Health Resources and Services Administration (HRSA), Department of Health and Human Services, in March 2001. The primary purpose of this grant was to facilitate the development of a plan for providing Arizonans with affordable, accessible health insurance, including technical and staffing support to the Task Force.

This section provides a general overview of the major activities undertaken by the Task Force. The activities described below have been grouped into the following three categories: Task Force meetings, policy briefing papers and data collection and public participation.

Task Force Meetings

Over the past year, the Task Force held eight meetings. These meetings served multiple functions, allowing Task Force members to hear formal presentations by experts in the community, to receive public testimony and to discuss key issues and solutions related to the provision of accessible and affordable health care coverage in Arizona.

Below is a brief description of the eight Task Force meetings. Actual meeting minutes for the Task Force can be found at http://www.azleg.state.az.us/iminute/iminutelinks.htm. In addition, handouts from the Task Force meeting can be found in Section 4 of this report.

- November 30, 2000: At this first meeting of the Task Force, the co-chairs reviewed the committee's purpose and goals. The rest of the meeting consisted of a series of formal presentations a number of which focused on the provision of health care in rural areas (e.g., problems in providing coverage, pull out of Medicare HMOs, cost factors). Information was also presented on risk pools and the role they play in addressing health care coverage issues. Lastly, overviews were provided on the Arizona HealthCare Group Program, Premium Sharing Demonstration Project and the Arizona Telemedicine Program.

- January 5, 2001: Similar to the first meeting, this meeting consisted of four formal presentations targeted at educating Task Force members about health care programs and coverage in Arizona. This included: (1) an overview of Proposition 204 and the implementation of increasing eligibility to 100 percent of the federal poverty level

(FPL); (2) a detailed description of the HealthCare Group Program and Premium Sharing Demonstration Project, including who is covered under these program; (3) a discussion of the health care marketplace in Arizona, identifying those populations with the greatest needs in terms of health coverage; and (4) an overview of the critical access hospital program being implemented in the State and the problems faced by rural hospitals in Arizona. Lastly, due to the magnitude of the health care coverage problem, Senator Cirillo presented a graphic presentation of the health care system in Arizona.

- May 14, 2001: Overviews were provided regarding relevant 2001 health care coverage legislation, the State Planning Grant and Medicaid expansion up to 100 percent FPL (i.e., Proposition 204 implementation). The key focus of the meeting was the development of an agreed upon set of basic principles for health care coverage in Arizona which are intended to serve as the framework for guiding the Task Force in the formulation of final recommendations. David Griffis facilitated this discussion which resulted in the identification of basic guiding principles along with a set of specific questions (criteria) to consider when developing strategies, models, etc. (See Section 3. Task Force Findings and Recommendations).

- August 23, 2001: AHCCCSA provided a brief update on the implementation of all the new expansion programs it will be implementing this year. The key focus of this meeting was the presentations by the AHCCCSA contracted consultants (i.e., William M. Mercer, Inc. and Milliman USA, Inc.) on the seven policy issue papers they had prepared. From these presentations, Task Force members discussed possible strategies for addressing the issue of health care coverage in Arizona including:

  - Targeting of small employer groups and individuals residing in rural areas of the state and the pre-retirement group.
  - Development of purchasing pools potentially building upon the existing HealthCare Group program.
  - Development of a high risk pool.
  - Development of additional strategies to address health care infrastructure issues in rural areas of the state.

- September 27, 2001: AHCCCSA presented a series of diagrams that portrayed health coverage in Arizona with a specific focus on publicly sponsored coverage and a diagram summarizing rural health care infrastructure strategies (see Section 4. Attachments). Based on Task Force inquiries William M. Mercer, Inc. presented follow-up information regarding the financial costs associated with recently enacted insurance mandates and demographic information on the sub-population of uninsured individuals 45 to 64 years-old. An update from the AHCCCS-HRSA Technical Advisory Committee was given which provided the Task Force with input on potential strategies being considered and setting forth some recommended strategies for the Task Force to consider.

- November 14, 2001: Two issues that were raised at the previous Task Force meeting (health insurance administration costs, elasticity of demand for health care) were addressed by William M. Mercer. In response to the Task Force interest in moving toward a self-insured program for state employees, William M. Mercer, Buck Consultants and Arizona Department of Administration made formal presentations on self-insured programs and state employee health care coverage. The Task Force reviewed a proposed draft of a statement of legislative intent, which ultimately served as the basis for proposed legislation. Clarification regarding the document was provided and members offered a number of suggested changes.

- November 26, 2001: The Arizona Association of Community Health Care Centers presented an overview of their 2002-2006 plan for expansion along with several recommendations to the Task Force (i.e., continuing to fund the primary care programs and clinic construction program and increasing funding for the state provider loan repayment program). A demographic overview of Arizona's population and health care coverage including characteristics of the uninsured population was presented by the Southwest Border Rural Health Research Center.

- December 11, 2001: Prior to discussing the proposed draft legislation, the Task Force listened to presentations that addressed follow-up issues raised by members. This included issues related to self-insurance, proposed HealthCare Group changes and additional demographic information regarding the uninsured population in Arizona. The key focus of the meeting was the review and discussion of the proposed draft legislation, along with the final adoption of recommendations (see Section 3 for a detailed discussion).

Briefing Papers and Data Collection

In addition to formal presentations by health care experts numerous briefing papers were prepared for Task Force members in order to help facilitate the identification of the most appropriate strategies for addressing the issue of affordable and accessible health care coverage. With the monies from the HRSA State Planning Grant, AHCCCSA contracted with a variety of consultants for the preparation of these briefing papers. The Task Force played an active role in determining the topics for these papers, which included a national perspective as well as a local focus.

National Perspective

For the national perspective ten policy issue papers were developed. These papers included, where appropriate, a summary of current approaches/best practices being used by other states and their experience, an evaluation of the pros and cons of the approach(es) in the context of the guiding principles developed by the Task Force and the identification of issues that need to be considered in adopting various approach(es). These papers are available on the AHCCCS-HRSA State Planning Grant web site www.ahcccs.state.az.us/Studies/default.asp?ID=HRSA.

These papers were completed by Milliman USA, Inc. (first four papers listed below) and by William M. Mercer, Inc. (last six papers listed below) and include:

- *Purchasing Pools* focuses on purchasing pools established for small employee groups and individuals/families and their effectiveness in improving access and affordability to health insurance.
- *High-Risk Pools* examines the types of risk pools implemented by other states to cover residents whose medical costs preclude them from obtaining coverage at affordable prices in the private market.
- *Implementation of Incentives and Regulatory Mandates to Increase Health Insurance Coverage* provides an overview of incentives that have been implemented by other states to increase private health insurance coverage as well as provides commentary on the effectiveness of legislative mandates at the state level. Strategies examined include: those targeted at the consumer (e.g., tax credits, premium sharing, discount cards), health plan/insurance company (e.g., premium tax, mandated rural coverage, premium regulation, limits on waiting periods) and employers (e.g., tax credits, mandated payroll deductions for those employees participating in health insurance program).
- *International Approaches to a Socialized Insurance System* provides a brief overview of the socialized medicine approach to the delivery of health care that has been operating in European and other select countries.
- *Faces of the Uninsured and State Strategies to Meet Their Needs* identifies and describes the key sub-populations that one needs to consider in addressing the issue of accessible and affordable health care coverage (e.g., low-income uninsured, working uninsured, rural uninsured) as well as a brief discussion of strategies used by states to address the needs of the specific sub-populations.
- *Initiatives to Improve Access to Rural Health Care Services* provides an overview of strategies that have been implemented by other states to increase access to health care in rural areas both in terms of increasing coverage and enhancing provider networks.
- *Arizona Basic Health Benefit Plan: A Comprehensive Review* examines the Arizona Basic Health Benefit Plan in the context of other states' approaches and critiques the plan in terms of benefit design variables as well as its overall affordability.
- *Health Insurance Administrative Costs* provides a brief discussion of the factors which impact administrative expenditures and provides percentages of total expenditures spent on administration by insurance plan types in 2000.
- *Elasticity of the Demand for Health Care Services* discusses the relationship between the demands for health care as it relates to the cost of care, arguing out that health insurance is relatively inelastic.
- *Review of Self-Insuring of Health Benefits* explains the features and differences between fully insured funding arrangements and self-insured funding, as well as minimum premium funding which is a combination of fully and self-insured.

Arizona Perspective

In addition to looking at strategies implemented in other states, a number of the briefing papers focused specifically on Arizona. These papers included the following:

- As a complement to the policy briefing paper developed by William M. Mercer, Inc. (*Initiatives to Improve Access to Rural Health Care Service*), AHCCCSA completed a paper which provides an inventory of the strategies that have been implemented in Arizona to address rural health care infrastructure issues.
- William M. Mercer Inc., completed a paper which examined the cost impact of recently enacted health insurance mandates in Arizona, e.g., direct access to chiropractic services, standing referral requirement and access to medical supplies.

In order to gain a more thorough understanding of Arizona's health care coverage and health insurance landscape, AHCCCSA engaged the University of Arizona, College of Public Health, Rural Health Office, Southwest Border Rural Health Research Center to analyze and compile information on:

- Population characteristics and employer composition at both the State and county level.
- Available health care coverage options in Arizona.
- Characteristics of Arizona's uninsured population.

This information was presented to the Task Force through two formal presentations made by the Southwest Border Rural Health Research Center.

Public Participation

Aside from the formal presentations by health care experts, the Task Force provided opportunities for the public to participate in a number of ways. The Task Force meetings were well attended (i.e., approximately 50 attendees) with representatives from insurance carriers, retirement groups, advocacy agencies, employee unions, hospital association, health facilities and county governments. Additionally, public testimony was provided by numerous individuals including:

- Arizona Bridge to Independent Living
- American Association of Retired Persons
- Arizona Citizen Act
- Community Physicians
- Arizona Pharmacy Association
- Arizona Interfaith / Valley Interfaith

Lastly, the Task Force members received public input from the AHCCCS-HRSA Technical Advisory Committee (TAC) established by AHCCCSA as part of the HRSA State Planning Grant. The TAC's purpose was to serve in an advisory capacity to both AHCCCSA and the Task Force, providing guidance in the development of plan options as well as feedback on

proposed approaches. The TAC was composed of representatives from the physician community, insurance companies (urban/rural, commercial and specialty), hospitals (rural and urban) and state agency directors of AHCCCSA and Department of Insurance. The TAC made a formal presentation to the Task Force at their September meeting. (See AHCCCS-HRSA project Web site for additional information about the TAC including the meeting minutes).

SECTION 3. TASK FORCE FINDINGS AND RECOMMENDATIONS

Early on in the process, the Task Force developed an agreed upon set of basic principles for health care coverage in Arizona which were intended to serve as the framework for guiding the Task Force in the formulation of their final recommendations. These guiding principles along with the Task Force's final recommendations are described below.

Guiding Principles

The Task Force agreed upon four basic guiding principles. These guiding principles are listed below along with a set of questions (criteria) to be answered when developing health care coverage strategies. The accompanying drawing (Diagram 1) summarizes these principles and restates the four fundamental beliefs of the Task Force.

Health care, especially basic benefits, should be available and accessible.

- Are the basic benefits (i.e., service coverage and limitations) clearly defined?
- Are the sub-populations eligible for coverage clearly defined including the coverage (or non-coverage) of non-US citizens?
- Are prevention services that will save money included as part of the basic benefit package? Can they be quantified?
- Will the benefit package provide the opportunity for improvement in health status and the delivery of quality care?
- Is the basic benefit package portable?
- What is the value (i.e., return on investment) of the basic benefit package?
- Does the package contain the appropriate incentives to support the guiding principles?
- Are the right services (plans and providers) available in the right places at the right times?
- Are there incentives in place to encourage providers to provide services where needed?
- Will consumers (e.g., employers, employees, non-employed individuals) use the services, i.e., minimal barriers and appropriate incentives?
- Do commercial carriers have the incentive to participate?

Health care should be affordable and properly financed.

- Have the costs been clearly identified, both short and long term?
- Have the associated financial risks been clearly identified?
- Can the State afford it? Can members afford it? Can carriers afford to offer it?
- Can the costs be appropriately managed?
- Is it financially self-sustaining and solvent over the long term?
- Does it foster and encourage consumer responsibility?

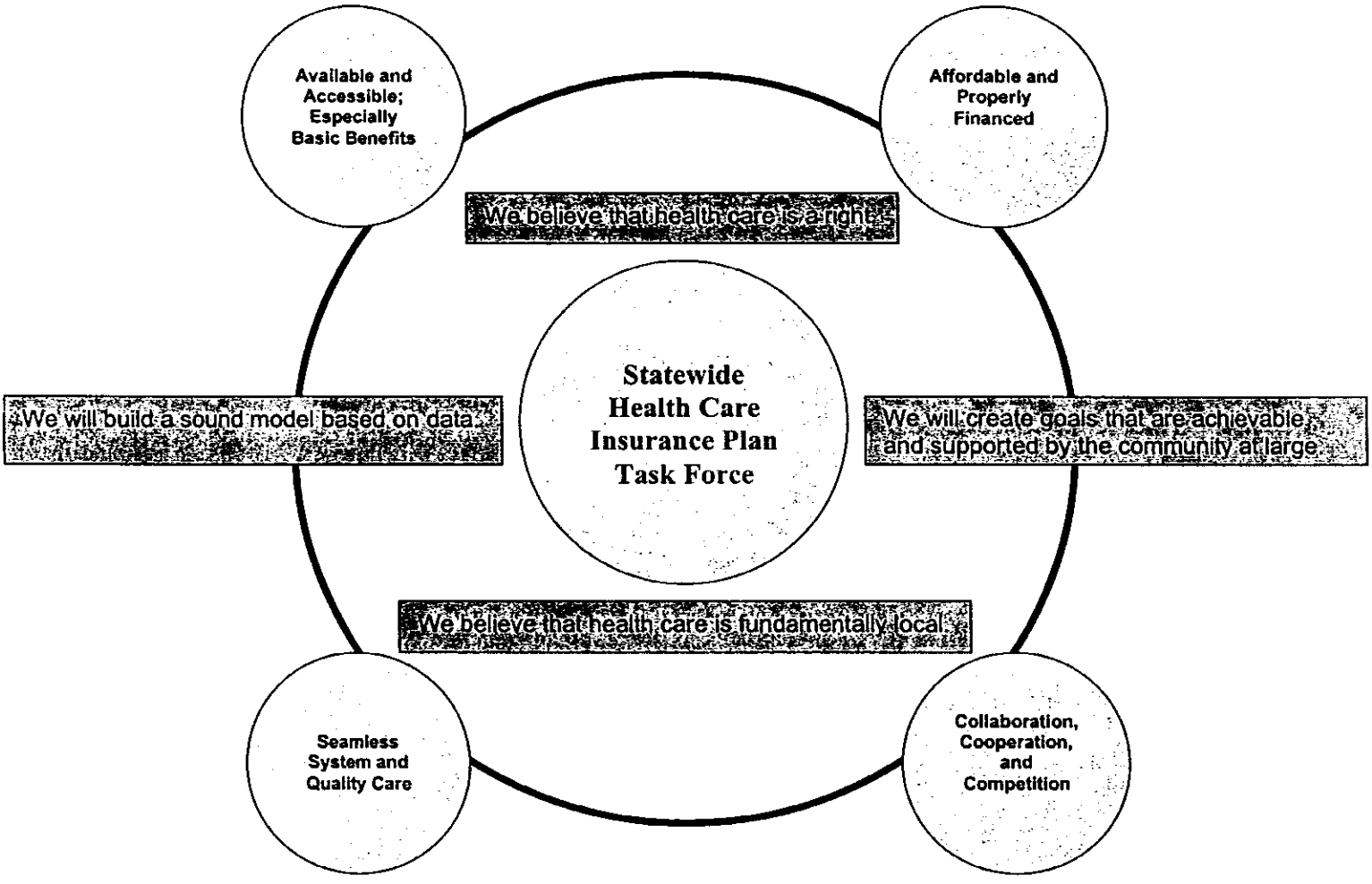
Health care should be provided through a seamless system, offering the highest quality care.

- Do pieces of the system fit together well minimizing fragmentation and duplication? Does interdependence and coordination exist between system pieces?
- Have the interrelationships between various programs been taken into consideration such as those sponsored by Title XIX/XXI, Mexican government, Indian Health Services.
- Is one stop shopping made possible in as many situations as practical?
- Are services/care coordinated including the ability to easily move from primary care to specialty?
- Is there the flexibility and adaptability to move pieces around?
- Does the system encourage the highest and best use of services?
- Does a continuum of services exist as the population ages?
- Is the model administratively simple, i.e., low on paperwork and low on hassles?

Health care should be done in collaboration and in cooperation with the various stakeholders both public and private sector and it should foster competition.

- Is there provider acceptance to the approach?
- Does it create an atmosphere that fosters competition, collaboration, and cooperation especially beyond primary care?
- Has the government's role in facilitating competition been made clear?
- Does it provide a way for dealing properly with providers?
- Does it encourage a better-informed consumer?
- Do the State's educational institutes, e.g., College of Medicine, Community Colleges, and other allied health-training program have a clearly defined role in supporting the system?
- Have the appropriate linkages to employers been established?
- Does the model have adequate links to economic / workforce development?
- Are commercial carriers involved in the model?

Diagram 1: Summary of Guiding Principles and Fundamental Beliefs



Final Recommendations

The Statewide Health Care Insurance Plan Task Force formally adopted two recommendations at its last meeting in December 2001. These recommendations are described in detail below.

Recommendation 1: Adoption of Proposed Enabling Legislation

The Task Force formally voted to adopt proposed enabling legislation that establishes a more defined framework within which the State can continue its efforts to develop a seamless health care system in Arizona through the implementation of various strategies over the next two to three years. More specifically this legislation, a copy of which is included as an attachment in Section 4, sets forth the following:

- Changes the name of the Task Force to the Statewide Health Care System Task Force; adding three additional members (i.e., persons from House of Representatives, Senate and University of Arizona Health Science Center) and extending the life of the committee until December 31, 2004.

- Requires the Task Force to make recommendations to:

  - Narrow the gap between existing public and private health coverage programs (e.g., through implementation of insurance reform, consumer and employer education initiatives, private-public coverage programs, program for cooperative purchase of employee healthcare benefits by small group employers).
  - Restructure current state employee and retiree health care coverage programs (e.g., self-insurance system and expansion of pool size).
  - Enhance existing public supported programs (e.g., effective outreach programs, expansion of coverage groups).
  - Improve the rural health care infrastructure through a variety of strategies including development of a plan to more effectively coordinate current rural health care resources and programs.

- Requires the Task Force to engage in a partnership for the statewide health program with the federal Centers for Medicare and Medicaid Services.

- Requires the Task Force to submit an annual report on or before November 15 to the Governor and Legislature.

This proposed legislation will be introduced during the 2002 Legislative Session.

Recommendation 2: Support of HealthCare Group Changes

While the current economic climate in Arizona does not lend itself to the implementation of new programs, the Task Force felt that it was important to try and maintain those programs that have

proven to play an effective role in making health care coverage accessible and affordable to Arizonans. To that end the Task Force supported the continuation of the HealthCare Group program and formally adopted a series of proposed changes to the program. While HealthCare Group would continue to target the small employer group marketplace between 1 and 50 employees and political subdivisions regardless of size, the adopted proposed changes included the following:

- Change the eligibility process for HealthCare Group by gathering sufficient household income information so that only those with no other public programs available to them are enrolled in HealthCare Group and have the ability to receive the state-only subsidies associated with the program.

- Streamline the benefit options offered under the managed care delivery system into a single uniform statewide coverage option including identical covered services, copays and benefits levels. Riders or other modifications would not be offered.

- Expand the HealthCare Group Administration to assume the primary responsibility for eligibility determination, enrollment and disenrollment with the HealthCare Group health plans focusing solely on the delivery and management of the care.

- Revise the underwriting methodology in order to develop a premium structure that uses an incremental scale based on employee age and household income. The scale can be coordinated with existing income eligibility guidelines for state and federal programs and can be set so persons with higher incomes will not receive state-subsidies.

SECTION 4. ATTACHMENTS

This list identifies the specific handouts from each of the Task Force meetings, copies of which are contained in this section.

I. 11/30/00 Meeting

A. Representative Carruthers' memo to Task Force members on problems of health coverage in rural Arizona
B. *Comparison of Six Arizona Rural Managed Care Center Counties* by Southwest Border Rural Health Research Center
C. Handout for Southwest Border Rural Health Research Center presentation entitled *Impact of Medicare HMO Pullout in Arizona Rural Counties*

II. 1/5/01 Meeting

A. Senator Cirillo's diagram of the health care system
B. Handout for the AHCCCS Administration Proposition 204 presentation
C. Handout for William M. Mercer presentation entitled *Research and Analysis of Population, Health Care Program Utilization, Access to Providers and Cost to Provide Care through State Funded and/or Administered Programs*

III. 5/14/01 Meeting

A. May 14, 2001 memo from Jason Bezozo to Task Force on Summary of 2001 Health Care Legislation
B. Overview of Health Resources and Service Administration State Planning Grant and Timeline
C. Overview of Proposition 204 Implementation
D. Process for the Development of Guiding Principles

IV. 8/23/01 Meeting

A. Update on Implementation of New AHCCCS Programs
B. Draft of Statewide Health Care Insurance Plan Task Force Guiding Principles
C. Accessing Arizona's Health Resources and Services Administration State Planning Grant Web Site
D. Handout for William M. Mercer Presentation on Policy Issue Papers: Identification of Sub-Populations, Strategies to Improve Rural Access to Health Care and Critique of Proposed Basic Benefit Package

E. Handout for Milliman USA Presentation on Policy Issue Papers: Incentives to Increase Health Coverage, State High Risk Pools, Purchasing Pools and International Health Care Delivery Systems

V. 9/27/01 Meeting

A. AHCCCS Administration Diagrams Related to Health Care Coverage in Arizona
B. Handout for William M. Mercer Presentation on Information Update from the Policy Papers: Uninsured Population Between 45 – 64 and Cost Impact of Health Benefit Mandates
C. Handout entitled *Update from the Technical Advisory Committee*

VI. 11/14/01 Meeting

A. Handout for William M. Mercer Presentation on Three Policy Issues: Health Insurance Administration Costs, Elasticity of Demand for Health Care and Health Insurance and Self-Insuring for Health Benefits
B. Handout for Buck Consultants Presentation on Self-Insurance and State Employee Health Care Coverage
C. Draft for Statement of Legislative Intent

VII. 11/26/01 Meeting

A. Handouts for Arizona Association of Community Health Care Centers Presentation entitled *Access to Primary Care – A Community Health Center Plan for Arizona (2002-2006)* and *Arizona Association of Community Health Center Members, November 30 2001*
B. Recommendations from Arizona Association of Community Health Care Centers to the Statewide Health Care Insurance Plan Task Force
C. Handout for Southwest Border Rural Health Research Center Presentation on Assessment of Arizona Health Care Coverage

VIII. 12/11/01 Meeting

A. Handout for William M. Mercer Presentation on Follow-up Information Related to Self-Funding Programs
B. Overview of Proposed Changes to HealthCare Group
C. Handout for Southwest Border Rural Health Research Center Presentation Follow-up Information Related to Assessment of Arizona Health Care Coverage
D. Draft of Proposed 2002 Legislation

ARIZONA
HOUSE OF REPRESENTATIVES

M E M O

TO: **Health Care Task Force Members**

FROM: **Rep. Jim Carruthers**

DATE: **November 30, 2000**

SUBJECT: **Statewide Health Insurance Reform – HB2050**

Statewide Health Insurance Reform – HB 2050, State Wide Health Plan allows for the appointment of a blue ribbon task force to research and examine the feasibility of creating and initiating a state operated and supervised health insurance program. The task force will report findings and make recommendations to the Governor, Speaker of the House, and President of the Senate.

The Task Force considerations will include but not be limited to the following:

1. Explore the feasibility of a state operated, state supervised, health insurance program inclusive of the elderly and young
2. Research ways to make health insurance more affordable and accessible as well as reduce the number of uninsured and underinsured Arizonan's
3. Develop strong enforceable accountability measures (patient protection, patient bill of rights)
4. Create insurance provider stability with obligations to complete contract agreements as well as pay the insured and health care providers in a timely manner.
5. Examine the benefits of participation of private insurance companies as well as the benefits of the state becoming self insured
6. Investigate expanding Arizona's rights and protections for persons with disabilities to include mental health and substance abuse
7. Review the decision making latitudes that leave medical decisions to insurance company personnel, rather than medical professionals
8. Create policies that prevent insurance companies from "cherry picking" or otherwise discouraging those with health risk from having quality health care protection
9. Study ways and means to develop reasonable access to quality medical care without traveling large distances by establishing and maintaining rural health clinics, full implementation of Telemedicine etc.
10. Record and submit findings and recommendations to the President of the Senate, Speaker of the House and Governor for further action.

MEMO

HOUSE OF REPRESENTATIVES
State of Arizona

Office of the Chief Clerk
Room 203 ~ House Wing
Capitol Building
Phoenix, Arizona 85007
Phone: 602-542-3032

IMPORTANT DEADLINES -- First Regular Session, 45th Legislature

1. Financial Disclosure Statements -- Wednesday, January 31, 2001

   Every "public officer" is required to file a financial disclosure statement with the Secretary of State each year on or before the 31st of January (ARS 38-541 - 38-545). Forms are provided by the Secretary of State's office.

2. Last day for prefiling of bills -- noon, Monday, January 8, 2001

   House Rule 8D: Bills, resolutions and memorials may be prefiled by any member-elect for introduction in the first regular session during the period following the filing of the certification of election until the first day of the regular session . . .

3. Last day for sponsorship of bills before the five bill limit begins -- 5:00 p.m., Monday, January 8, 2001

   House Rule 8C: . . . Every bill, resolution or memorial shall have at least one prime sponsor. A member may not be the prime sponsor of more than five bills introduced after the first day of each regular session. For the purposes of this rule the first name on a bill shall be considered the prime sponsor.

4. Last day for introduction of bills -- Monday, February 5, 2001

   House Rule 8C: Bills, resolutions and memorials may be introduced during the first 29 days of regular session . . . Thereafter, with the exception of death resolutions, introduction may be allowed only with the permission of the Rules Committee.

5. Last day for House consideration of House Bills -- Friday, March 9, 2001

   House Rule 9F: . . . all House Bills shall be considered by committees prior to the Saturday of the week in which the 60th day (March 8) of session falls .

6. Last day for House consideration of Senate Bills -- Friday, April 6, 2001

   House Rule 9F: . . . all Senate Bills shall be considered by committees prior to the Saturday of the week in which the 90th day (April 7) of session falls . . .

7. Last day for consideration of bills in Conference Committees -- Friday, April 13, 2001

   House Rule 17G: . . . Conference Committees shall consider all bills prior to the Saturday of the week in which the 97th day (April 14) of session falls . . .

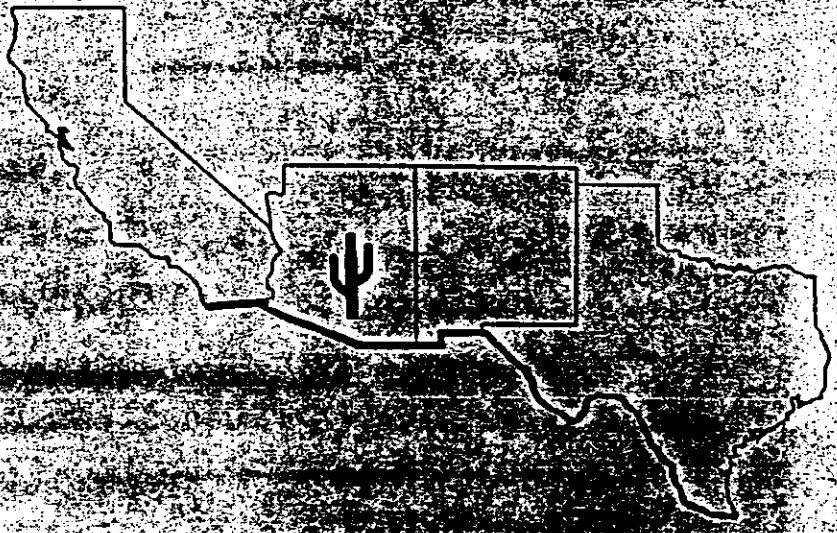
8. Adjournment sine die -- Saturday, April 21, 2001

   House Rule 2A: . . . regular sessions shall be adjourned sine die no later than the Saturday of the week in which the 100th day (April 17) of session falls. (The Speaker and the President may extend the session for a period not to exceed seven additional days. Thereafter, the session can be extended only by a majority vote of the Members.)

CC Office
1/9/01
deadlines 01.doc

Comparison of the Six Arizona Rural Managed Care Center Counties

Monograph 39



Southwest Border Rural Health Research Center
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TEL: (520) 626-7946
FAX: (520) 326-6429

Comparison of the Six Arizona Rural Managed Care Center Counties

Monograph 39

Howard J. Eng, Dr.P.H.

November 2000

The Arizona Rural Managed Care Center is supported by Grant No. HS08620-05 from the Agency for Health Care Policy and Research.

SOUTHWEST BORDER RURAL HEALTH RESEARCH CENTER

The Southwest Border Rural Health Research Center (SBRHRC) is the research unit of the University of Arizona Rural Health Office. The SBRHRC is one member of a network of rural health research centers originally funded by the Federal Office of Rural Health Policy. The Center receives funding from federal agencies, private foundations, and the State of Arizona.

MISSION STATEMENT

The mission of the Southwest Border Rural Health Research Center is:

- To conduct policy-relevant (action or applied) research which addresses health issues that affect the Southwestern United States and the U.S.-Mexico border region;
- To disseminate research results to influence policy in such areas as: access to preventive services and primary care, especially for the socioeconomically disadvantaged and underserved; minority populations and health disparities; health professional distribution; health care financing; barriers to health care utilization; and prevention and treatment of substance abuse;
- To carry out program evaluations which focus on the same issues;
- To provide learning opportunities for university students to develop their skills and expertise in research and evaluation, and to provide technical assistance in these two areas to rural communities; and
- To collaborate with institutions and communities throughout the Southwestern United States and Mexico.

ARIZONA RURAL MANAGED CARE CENTER

The University of Arizona Rural Health Office (RHO) is one of five sites selected and designated by the Agency for Health Care Policy and Research (AHCPR) as a Rural Managed Care Center in Fall 1994. The other center sites are: Maine, West Virginia, Oklahoma, and Nebraska/Iowa. The Arizona Rural Managed Care Center (RMCC) is housed in the Rural Health Office and administered through the Southwest Border Rural Health Research Center. The RMCC facilitates the development and implementation of demonstration projects for the expansion and promotion of managed care that will lead to increased access to primary care and preventive services for rural residents. The lessons learned from RMCC demonstrations may provide the foundation for future policy decisions regarding the expansion of managed care in rural America. This comparison of the six Rural Managed Care Center counties is published as one of the Southwest Border Rural Health Research Center Monographs.

ACKNOWLEDGMENTS

The author would like to thank the following agencies and individuals for their assistance in providing data with this monograph:

Arizona Department of Health Services (ADHS)
Arizona Health Care Cost Containment System (AHCCCS)
Arizona Department of Economic Security (DES)
Arizona Association of Community Health Centers
Arizona Department of Insurance

Linda Bylow, Arizona Health Care Cost Containment System
Leigh Cheatham, Arizona Health Care Cost Containment System
Tim Flood, Arizona Department of Health Services

Members of the RMCC State Advisory Committee: Linda Bylow, Douglas Hirano, and Andrew Nichols; Cochise County Coalition for Primary and Prevention Health Care: Chris Cronberg, Betty King and Jennifer Ryan; Graham County Healthy Community Coalition: Donna Coca, Neil Karnes and Karl Johnson; and Pinal County Collaborative Health Care Network: Jack Beveridge, Al Gugenberger and Susanne Straussner for their review and comments of this report.

The author would also like to thank the following Rural Health Office staff and Masters in Public Health students for their assistance in the data collection, preparation, editing, and distribution of the monograph: Mohamed Shamsuddin, Ishrat Khandokar, Allison Connolly, Cynthia Jeffery, Leila Shehab, Cindy Resnick, Barbara Clarihew, Lee Ann Norvelle, and Heather Buehring.

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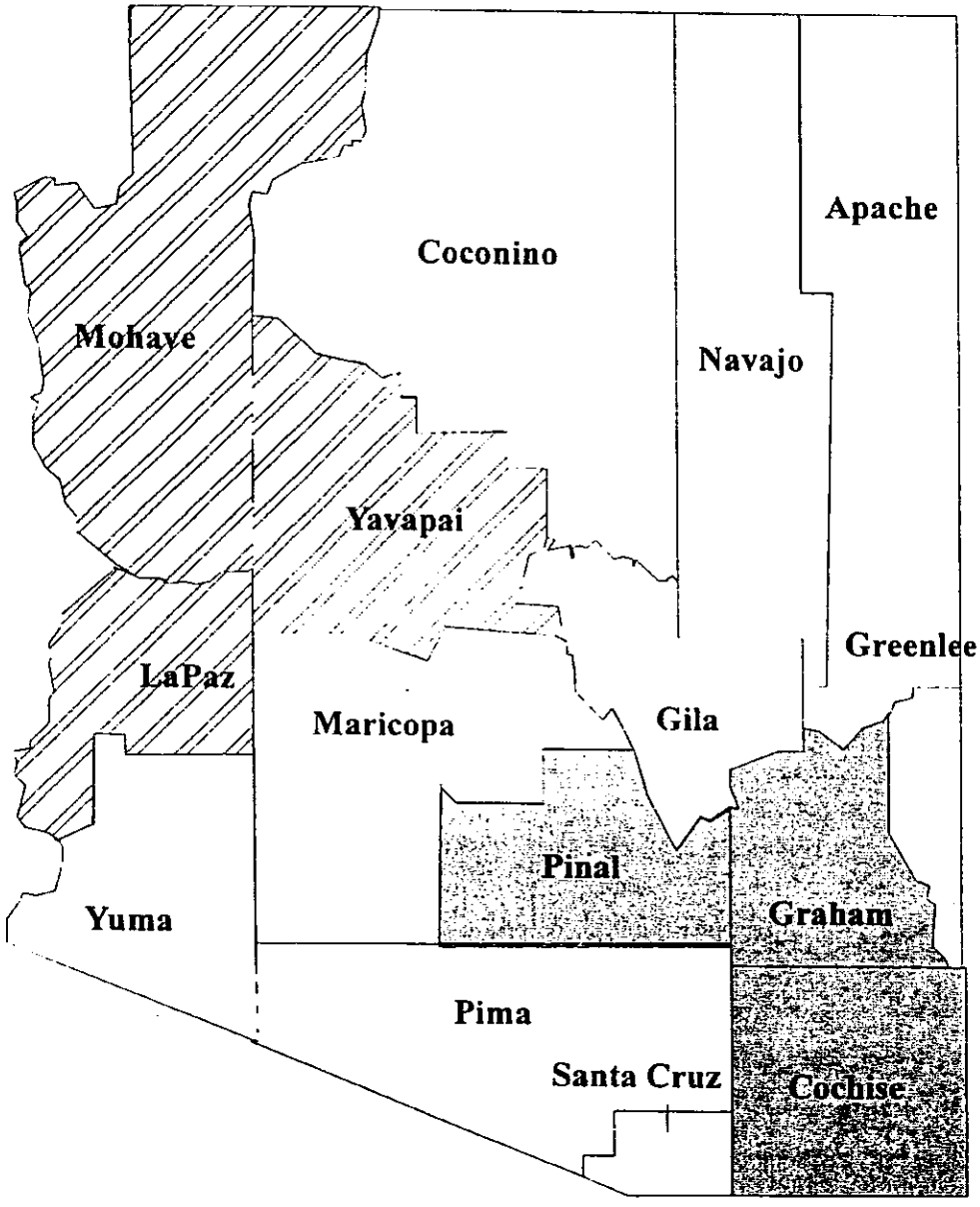
LIST OF ABBREVIATIONS

AAPCC	Adjusted Average Per Capita Cost
ADHS	Arizona Department of Health Services
AFCA	Arizona Family Care Associates
AHCCCS	Arizona Health Care Cost Containment System
AHCPR	Agency for Health Care Policy and Research
AHSC	Arizona Health Sciences Center
APIPA	Arizona Physician's IPA
AzHCon	Arizona Health Concept
AzMUA	Arizona Medical Underserved Area
CEO	Chief Executive Officer
CHA	Cochise Health Alliance
CHIP	Children's Health Insurance Program
CNM	Certified Nurse Midwife
ComCon	Community Connection
CPS	Current Population Survey
DES	Department of Economic Services
DO	Doctor of Osteopathy
DPT	Diphtheria, Pertussis, and Tetanus
ER	Emergency Room
FP	Family Practice

FPL	Federal Poverty Level
GAO	U.S. General Accounting Office
GP	General Practice
GS	General Surgeons
GYN	Obstetrics/Gynecology
HMO	Health Maintenance Organization
HPSA	Health Professional Shortage Area
IHS	Indian Health Service
IM	Internal Medicine
IMR	Infant Mortality Rate
IPCU	Index of Primary Care Underservice
MC	Managed Care
Mcare	Mercy Care Plan
MCO	Managed Care Organization
MD	Medical Doctor
MSA	Metropolitan Statistical Area
MUA	Medically Underserved Area
MUP	Medically Underserved Populations
MN/MI	Medically Needy/Medically Indigent
NP	Nurse Practitioner
OBS	Obstetrics/Gynecology
OBG	Obstetrics/Gynecology

OE	Open-Ended
PA	Physician Assistant
PCA	Primary Care Area
PD	Pediatrics
PHO	Physician Hospital Organization
POS	Point of Service
PPO	Preferred Provider Organization
PSP	Premium Sharing Pilot Program
RHO	Rural Health Office
RMCC	Rural Managed Care Center
SBRHRC	Southwest Border Rural Health Research Center
SFP	Sobra Family Planning
Sobra Kick	Sixth Omnibus Budget Reconciliation Act
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families

ARIZONA AHCPR RURAL MANAGED CARE PROJECT DEMONSTRATION AND COMPARISON COUNTIES



Demonstration Counties

Comparison Counties

EXECUTIVE SUMMARY

In 1995 and 1996, the Arizona Rural Managed Care Center (RMCC) had selected six of the state's 12 rural counties as demonstration and comparison study sites. The selection of these counties was based on the number of the 30 most underserved Primary Care Areas in 1994. In 1994, the Arizona Medically Underserved Areas were designated from the 102 Primary Care Areas (PCAs). A PCA is defined as "a geographical area in which most residents seek primary health services from the same place(s)." The PCAs encompass the major towns for which they are named, and the surrounding areas. There were nine top 30 medically underserved Primary Care Areas in the demonstration counties (Pinal - 4, Cochise - 3, and Graham - 2) and six in the comparison counties (La Paz - 2, Mohave - 2, and Yavapai - 2).

During the five-year project, the RMCC worked in partnership with the demonstration counties to develop and use innovation in the organization, financing, and delivery of health services to expand, strengthen, and/or promote managed care networks. These networks would increase access to primary care and preventive services for those rural residents who are uninsured and/or not receiving needed medical services. The RMCC used a variety of strategies to identify, design, and implement its demonstration activities and developed collaborative approaches, some ongoing, others ad hoc, that matched the diversity of health care systems presented in the three demonstration counties. The Center staff provided technical assistance to the demonstration counties to facilitate the planning and implementation of the demonstration projects.

The demonstration counties achieved greater improvement in providing access to primary health care for their residents than the comparison counties during the five-year period. In 2000, the number of top 30 medically underserved Primary Care Areas decreased by three in the demonstration counties (Pinal - 3, Cochise - 3, and Graham - 0), but increased by four in the comparison counties (La Paz - 3, Mohave - 4, and Yavapai - 3). There was also a decrease in the number of the top 10 medically underserved PCAs for the demonstration counties (1994 - 2 and 2000 -1), while there was a significant increase for the comparison counties (1994 - 3 and 2000 - 6).

INTRODUCTION/BACKGROUND

In the Fall of 1994, the University of Arizona Rural Health Office (RHO) was one of five sites selected and designated by the Agency for Health Care Policy and Research (AHCPR) as a Rural Managed Care Center (RMCC). The other RMCCs are located in Maine, West Virginia, Oklahoma, and Nebraska/Iowa. During the 5-year project period, the Rural Managed Care Centers assisted in the development of demonstration projects designed to increase access to primary care and preventive services by rural underserved populations.

The Arizona RMCC is supported by a multi-disciplinary and multi-institutional state consortium and an advisory committee. The AHCPR Consortium is comprised of representatives from the Arizona Health Sciences Center (AHSC), the Arizona Health Care Cost Containment System (AHCCCS), the Arizona Department of Health Services (ADHS), and the Rural Health Office (RHO). The AHCPR Advisory Committee includes the consortium members. Other members of the committee include representatives from health care practitioner associations who provide services to the rural areas, rural health care delivery systems, managed care plans, the Indian Health Service, consumer groups, the Governor's Office and the County Supervisors Association of Arizona.

About 65 million persons, or one-quarter of the U.S. population, reside in rural areas. An important component of national health care policy is to assure access to health care services in rural areas.[1] There are three major goals for the Arizona AHCPR Rural Managed Care Center. These are:

1. To increase access to primary care and preventive services for those Arizona residents who are currently uninsured and/or not receiving needed medical services in the targeted rural counties.

2. To develop and use innovations in the organization, financing, and delivery of health services to the targeted underserved rural population that will lead to the expansion and promotion of managed care networks in the demonstration counties. The Arizona Rural Managed Care Center provides technical assistance to the targeted counties to facilitate the establishment and/or growth of these networks.

3. To work with the Arizona Health Care Cost Containment System (AHCCCS), privately managed health care groups, non-managed health care delivery systems, demonstration counties, and other interested parties in planning and implementing methods that will increase access to primary care and preventive services by the targeted underserved rural populations.

The RMCC project staff identified, collected, and reviewed data resources related to Arizona population demographics, health care financing, health status, and access to health care. There were four medical underservice indicators reviewed. The most useful was the Arizona Medically Underserved Area (AzMUA), which is developed by the Office

of Health Planning, Evaluation and Statistics, Arizona Department of Health Services (ADHS). Three of these were less useful. These are (1) the Federal Health Professional Shortage Areas (HPSAs); (2) the Federal Medically Underserved Areas (MUAs); and (3) Federal Medically Underserved Populations (MUPs). Refer to the map in Appendix A for Arizona Medically Underserved Areas in 1995.

In 1994, the AzMUAs were designated from the 102 Primary Care Areas (PCAs). A PCA is defined as "a geographical area in which most residents seek primary health services from the same place(s). The PCA is meant to depict the primary care service seeking patterns of the residents."[2] The PCAs encompass the major towns for which they are named, and the surrounding areas. Twenty-one of the 102 PCAs are on Indian Reservations. The Arizona Department of Health Services uses the Index of Primary Care Underservice (IPCU) to designate AzMUA's Index, which comprises five components: (1) availability of practitioners; (2) geographic accessibility; (3) income/ability to pay; (4) health status; and (5) "wild cards" (which include indicators such as infant mortality rate, percent of elderly population, percent of unemployed, etc.). Appendix A provides a detailed description of the Index.

The primary reasons for using PCA data are the following:

- The PCA Statistical Profiles identify the primary care areas in each county and designate Arizona Medical Underserved Area (AzMUA) based on the above indicators. By ranking these PCA scores, the top 75th percentile, or approximately 30 of the worst PCAs in the state, are designated. Those who work in local agencies and organizations addressing health care issues can use this designation to prioritize community needs (See Appendix B for the 1994 and 2000 lists).

- Most of the IPCU indicators are averaged over a five-year period from 1990 to 1994. In communities with small populations, a small increase in one indicator, such as the death of an infant, can have a large effect on the infant mortality rate (IMR). By averaging the values over a few years, the indicators are more stable and, thus, more meaningful for comparison.

However, PCA data should be used carefully since a PCA may overlap more than one county. For example, Apache Junction PCA covers a portion of Maricopa County. Residents in both the Pinal and Maricopa county portions of Apache Junction may go to the Phoenix area for health service because of its proximity to the metropolitan area.

The project team, in April 1995, presented to the State Advisory Committee a review of data related to the twelve rural counties that do not have any community more than 50,000 population. Pinal County has four of the 30 most underserved PCAs, and Cochise County has three. The rest of the rural counties have two or less. The project team recommended that Pinal and Cochise Counties be the first two demonstration sites. After a lengthy discussion, the committee gave its approval. In October 1996, the State Advisory

Committee selected Graham County as the third rural demonstration county and three comparison counties (La Paz, Mohave, and Yavapai). The same criteria used to select the first two rural demonstration counties (Cochise and Pinal), were used to select the remaining four counties. The four counties had two of the 30 most underserved PCAs in 1994.

This report provides a comparison of the six RMCC counties with regard to population demographics, selected health services resource availability, health care financing (e.g., managed care), health services utilization, and health status. The data presented in this report is derived from several sources. These include surveys, census data, and local, state and national studies and reports. Most of the data related to health status are from ADHS' "Arizona Health Status and Vital Statistics" and "Primary Care Area (PCA) Statistical Profiles."

COUNTY CHARACTERISTICS

This monograph provides a comparison of the six RMCC counties. The three demonstration counties, Cochise, Graham, and Pinal, are compared to La Paz, Mohave, and Yavapai. The demonstration counties are located in the southeast quadrant of the State of Arizona while the comparison counties are located in the northwest quadrant of the state. The three comparison counties are *italicized* in the monograph tables.

Demonstration Counties: Cochise County is located in the southeastern corner of the state. It is bordered to the north by Graham and Greenlee Counties and to the west by Pima and Santa Cruz Counties, to the east by the state of New Mexico, and to the south by the Mexican state of Sonora. The county was named for an Apache chief in 1881, when Tombstone was the county seat and one of the largest cities in the western United States. In 1929, the county seat was moved to Bisbee, where it remains. Sierra Vista is its largest city.

The population of 120,179 (1999) inhabits a region of 6,219 square miles. It is as large as Connecticut and Rhode Island combined. Individual and corporate ownership account for 40 percent of the county's land, the state owns 34.6 percent, the U.S. Forest Service and Bureau of Land Management own 22.2 percent, and the public own the remaining 3.2 percent. There are no Indian reservations within the county. Mining, once a significant industry, has declined, but agriculture, including livestock and crops, continues to be of economic importance. In addition, manufacturing, service industries, tourism, and the U.S. Army's Fort Huachuca are major sources of employment. At the beginning of the RMCC project, there were five PCAs in the county; now, there are seven.

Graham County is located in southeastern Arizona. Its southern boundary is Cochise County; its western boundary is Pinal County; its eastern boundary is Greenlee County, and its northern boundary comprises Navajo and Apache Counties. Prior to the formation of Greenlee County, Graham County was almost twice its present size. The major cities

and communities in Graham County are Pima, Safford, and Thatcher. Safford is the largest city of the three and the county seat.

Graham County is 4,630 square miles, 22 of which is water. In 1999, it had a population of 34,245. The San Carlos Indian reservation covers approximately one-third of the land. Individuals and corporations own 9.9 percent of the land; the state of Arizona owns 18 percent; the U.S. Forest Service and Bureau of Land Management own 38 percent; and the Indian Reservation owns 36 percent. Graham County increased the number of PCAs from two to three.

Pinal County is located in southern Arizona, bordered by two major metropolitan counties and two rural counties. Maricopa County, including the Phoenix metropolitan area, borders the northern and western limits of Pinal, while Pima County, including Tucson, defines the southern limit. The northeast and eastern boundaries are defined by Gila and Graham Counties, respectively. The area, which now makes up Pinal County, was originally part of both Maricopa and Pima Counties; a petition by residents in 1875 resulted in its county designation, with Florence as the county seat.

In 1999, the population of 157,413 resided in a region of 5,344 square miles, of which 30 are water. Individuals and corporations own 26 percent of the land; the state of Arizona is the largest landholder, with 35 percent, Indian reservations own 23 percent, U.S. Forest Service and Bureau of Land Management controlling 15 percent and 1 percent other public land. The County includes portions of four reservations: the Gila River, Ak-Chin, Tohono O'odham, and San Carlos Indian Reservations. The county is divided into two regions by both geographical and economic distinctions. The eastern portion of Pinal is mountainous, with elevations up to 6,000 feet, and copper mining as a major industry. These communities include Superior, Kearny, Mammoth, San Manuel and Oracle. Western Pinal is a low desert valley, with irrigated agriculture a predominant feature. Some communities have diversified their economic bases with manufacturing, trade, services, tourism and retirement communities. Apache Junction and Casa Grande are the largest cities. There are 11 PCAs in the county that include the Ak-Chin and Gila River Indian Community PCAs.

Comparison Counties: La Paz County is located on the western part of Arizona. The county is bordered by Yuma County on the south, Maricopa and Yavapai Counties on the east, state of California on the west, and Mohave County on the north.

The population of La Paz County in 1999 was 19,821. The county is 4,518 square miles, 30 of which is water. The U.S. Bureau of Land Management controls 58.3 percent of the land; the state of Arizona, 8.8 percent; other public lands, 19.5 percent; and 5.3 percent of the land is owned privately and by corporations. The Colorado River Indian Tribes own 8.1 percent of the land. La Paz is the third smallest of Arizona's counties and has the lowest population density, with slightly more than four persons per square mile. The largest city is Parker, which is also the county seat. The major industries of La Paz County

are agriculture, tourism, and light manufacturing. All of La Paz County is designated an Enterprise Zone. La Paz has four PCAs including the Colorado River Indian Tribes PCA.

Mohave County is located in the northwestern corner of Arizona. It is bordered to the north by the state of Utah, to the east by Coconino and Yavapai Counties, to the south by La Paz County, and to the west by the states of California and Nevada. Mohave is the second largest county in Arizona. It has 13,479 square miles, of which 186 square miles are water, the remainder being almost all desert. Since 1887, Kingman has been Mohave's county seat.

The population of Mohave County in 1999 was 142,600. The U.S. Forest Service and the Bureau of Land Management own 55.2 percent of the land; Indian reservations own 6.7 percent; the State owns 6.6 percent; individuals or corporations own 17.2 percent, and the public own 14.3 percent. The major industries of Mohave County are manufacturing, tourism, ranching, warehouse/distributing, and mining. A major tourist attraction is the county's great water sports centers. The largest cities are Lake Havasu City, Kingman, and Bullhead City, respectively. Both Lake Mohave and Lake Havasu play an important role in the growth of Lake Havasu City and Bullhead City. Mohave County has nine PCAs, three of which are tribal PCAs (Kaibab Paiute, Hualapai, and Fort Mohave).

Yavapai County is in central Arizona and is bordered by Coconino County to the north and east, Gila County also to the east, Maricopa County to the south, and La Paz and Mohave Counties to the west. It was founded in 1864 and is one of Arizona's four original counties. The county is 8,125 square miles (approximately the size of the state of New Jersey).

The county population is 148,428. The largest city is Prescott, which is also the county seat. The U.S. Forest Service owns 38 percent of the land, while the State of Arizona owns 24.6 percent. Twenty-five percent is individually owned, and 11.6 percent is owned by the US Bureau of Land Management. The Yavapai Indian Reservation and the public each own less than 0.5 percent of the county. The major industries are tourism, recreation, ranching, and copper mining. There are seven non-tribal PCAs and one tribal PCA (Yavapai-Prescott) in the county.

COUNTY POPULATION DEMOGRAPHICS

The population of Arizona grew from 4,071,650 in 1994 to 4,842,987 in 1999, an 18.9 percent increase, according to the Arizona Department of Economic Security, Population Statistics Unit. During the same period, the three comparison counties had a greater population growth (19.6%) than the three demonstration counties (12.6%). Among the demonstration counties, Pinal County had the greatest population increase (19.0%) followed by Graham (11.8%) and Cochise (11.0%). Of the six counties, Pinal has the largest population with 3.3 percent of the overall state population, while La Paz has the smallest population, with only 0.4 percent of the overall state population. Table 1 provides population estimates for the six RMCC counties and Arizona for 1994 to 1999.

Tables 2, 3, and 4 provide county and state data summaries for gender, age, and race. All three demonstration counties and La Paz County have a higher percentage of males than females. The two other comparison counties show higher numbers of females-to-males, similar to the state gender patterns.

In five counties, the largest proportion of the population lies in the 20-44 years of age group, except for Yavapai County. The next largest age group for the demonstration counties was 0-14 years and for the comparison counties, 45-65 years (La Paz and Mohave) and 65+ years (Yavapai). The age group with the smallest representation in each county lies between 15 and 19 years.

The White and Nonwhite proportion of the three demonstration counties and La Paz are very similar, more than 35 percent of the county population is minority. For the four counties, Hispanics comprise the largest minority group (22.7% to 29.7%). The American Indian populations comprise the second largest minority group for three of the four counties (Graham and La Paz - 14.5% and Pinal - 8.1%). In contrast, Anglos make up more than 90 percent of the population in Mohave and Yavapai Counties.

Table 5 summarizes the high school graduates, unemployment, median household income, below 100% of Federal Poverty Level (FPL), and below 200% FPL percentages. In five counties, the high school graduation rate is lower than the state. The three demonstration counties and La Paz have higher unemployment and below 100% FPL percentage than the state. All six counties have lower median household income and higher below 200% FPL percentages than the state.

Table 1 Population Estimates for the Six RMCC Counties and Arizona: 1994-99*

County	1994	1995	1996	1997	1998	1999
Cochise	108,225	112,000	114,925	119,650	118,492	120,179
Graham	30,625	30,050	31,150	32,575	33,263	34,245
Pinal	132,225	139,000	144,150	150,375	153,079	157,413
La Paz	*16,075*	*16,700*	*18,200*	*17,625*	*19,310*	*19,821*
Mohave	*120,325*	*125,150*	*127,700*	*133,550*	*137,628*	*142,600*
Yavapai	*123,500*	*130,300*	*134,600*	*142,075*	*143,942*	*148,428*
Arizona	4,071,650	4,307,150	4,462,300	4,600,275	4,722,097	4,842,987

Source: Arizona Department of Economic Security (DES) Research Administration, Population Statistical Unit.
* Number of residents estimated as of July 1, 1994 - 1999. The three comparison counties are *italicized.*

Table 2 Population by Gender for the Six RMCC Counties and Arizona, 1999*

County	Total	Female	Male
Cochise	120,179	57,722 (48.0%)	62,457 (52.0%)
Graham	34,245	15,787 (46.1%)	18,458 (53.9%)
Pinal	157,413	75,030 (47.7%)	82,383 (52.3%)
La Paz	*19,821*	*9,199 (46.4%)*	*10,622 (53.6%)*
Mohave	*142,600*	*71,353 (50.0%)*	*71,246 (50.0%)*
Yavapai	*148,428*	*76,168 (51.3%)*	*72,260 (48.7%)*
Arizona	4,842,987	2,428,696 (50.1%)	2,414,291 (49.9%)

Source: Arizona Department of Economic Security (DES) Research Administration, Population Statistical Unit and Population Division, U.S. Bureau of the Census.
* Percent of population female and male based on 1990 Census.
The three comparison counties are *italicized.*

Table 3 Population by Age for the Six RMCC Counties and Arizona, 1999*

County	Total	0-14 yrs	15-19 yrs	20-44 yrs	45-64 yrs	65+ yrs
Cochise	120,179	26,624	9,312	41,066	25,907	17,270
Graham	34,245	8,719	3,085	12,379	5,975	4,087
Pinal	157,413	35,919	11,577	50,521	34,671	24,725
La Paz	*19,821*	*3,675*	*1,253*	*5,710*	*4,999*	*4,184*
Mohave	*142,600*	*27,446*	*8,425*	*38,033*	*34,428*	*34,298*
Yavapai	*148,428*	*25,950*	*9,180*	*37,612*	*36,632*	*39,054*
Arizona	4,842,987	1,078,983	335,584	1,773,118	977,009	678,293

Source: Arizona Department of Economic Security (DES) Research Administration, Population Statistical Unit and Population Division, U.S. Bureau of the Census.
* Number of residents estimated by age group as of July 1, 1999.
The three comparison counties are *italicized.*

Table 4 Population by Race for the Six RMCC Counties and Arizona, 1999*

County	Total Pop.	Anglo %	Hispanic %*	American Indian %	African Am %	Asian Am %	Other %
Cochise	120,179	63.0	29.1	0.7	4.9	2.2	0.1
Graham	34,245	58.1	25.2	14.5	1.8	0.4	0.0
Pinal	157,413	59.2	29.3	8.1	3.0	0.4	0.1
La Paz	*19,821*	*61.4*	*22.7*	*14.5*	*0.7*	*0.6*	*0.1*
Mohave	*142,600*	*91.8*	*5.3*	*2.1*	*0.3*	*0.5*	*0.0*
Yavapai	*148,428*	*91.3*	*6.4*	*1.5*	*0.7*	*0.4*	*0.1*
Arizona	4,842,987	71.7	18.8	5.2	2.9	1.4	0.1

Source: Arizona Department of Economic Security (DES) Research Administration, Population Statistical Unit and Population Division, U.S. Bureau of the Census.

* Those of Hispanic Origin may be of any race.

Total population percent represented by major ethnic/racial groups based on 1990 Census annualized to current year.
The three comparison counties are *italicized*.

Table 5 High School Graduates, Unemployment, Median Household Income, Below 100% of Federal Poverty Level, and Below 200% of Federal Poverty Level Percentages for the Six RMCC Counties and Arizona, 1999

County	Percent[1] High School Graduates	Percent[2] Unemployed	Median[3] Household Income	Percent[3] Below 100% Poverty	Percent Below[3] 200% Poverty
Cochise	75.7%	5.5%	$23,639	20.3%	45.3%
Graham	67.6%	8.2%	$19,225	26.7%	56.3%
Pinal	65.4%	5.3%	$21,808	23.6%	49.3%
La Paz	*63.0%*	*7.8%*	*$17,080*	*28.2%*	*58.1%*
Mohave	*72.8%*	*4.2%*	*$25,055*	*14.2%*	*37.9%*
Yavapai	*78.9%*	*3.2%*	*$22,715*	*13.5%*	*37.8%*
Arizona	78.7%	4.2%	$29,953	15.7%	35.8%

Source: Arizona Department of Economic Security (DES) Research Administration, Population Statistical Unit and Population Division, U.S. Bureau of the Census.

[1] Percent of population 25 years of age or older with high school education based on 1990 Census.

[2] Average percent unemployment for January through December 1999

[3] Medium household income, percent below 100% FPL and below 200% FPL as reported in 1990 Census.

The three comparison counties are *italicized*.

HEALTH SERVICES RESOURCES

This section summarizes the availability of health care resources in the six counties. When comparing the state ratios for selected health care resources, all six rural counties generally have fewer resources compared to the state's population-to-resource ratios (refer to Table 6). For example, five of the six counties have fewer hospital beds per 1,000 residents (Pinal - 0.92 to La Paz - 2.03) than the state (2.08). Only Yavapai County is slightly more, at 2.09. These ratios do not include federal hospitals such as the Raymond W. Bliss Army Community Hospital at Fort Huachuca in Cochise County and Hu-Hu-Kam Hospital at Sacaton in Pinal County. Cochise, Pinal, Mohave and Yavapai Counties have community-based primary care clinics. These include the two Federal Qualified Health Centers (FQHC) in Cochise and Pinal Counties.

The primary data source for Table 6 is the Primary Care Area (PCA) Profiles from the Bureau of Health Systems Development, Arizona Department of Health Services (April 2000).[3] According to the documentation of PCA Statistical Profiles, primary care practitioners are defined as physicians (Medical Doctor - MD, Doctor of Osteopathy - DO) and mid-level practitioners (Physician Assistant - PA, Nurse Practitioner - NP, Certified Nurse Midwife - CNM) with active licenses, residing in Arizona, whose primary or secondary specialty is in one of the following primary health care specialties: Family Practice (FP), General Practice (GP), Internal Medicine (IM), Pediatrics (PD), or Obstetrics/Gynecology (GYN, OBS, OBG).

The primary care physician numbers are not available in the PCA county profiles. The primary care physician numbers presented in Table 6 are obtained from the Arizona State Board of Medical Examiners' *Professional Directory and Resource Handbook* and Arizona Osteopathic Medical Association's *Membership Directory*. The same classification used by the PCA profiles for primary care physicians is used for determining the number of primary care physicians in each of the six counties.

Some physicians who provide primary care services in rural areas are not included as primary care physicians by the PCA definition. General surgeons (GS) and practitioners who practice full-time in state correctional institutions, Indian Health Service hospitals, or military base hospitals are not included. One of the limitations of using PCA data is that its source of primary care practitioner numbers is from health care professional boards' registration listings that may not be current or may not reflect practitioner changes in the county. The primary care physician ratios provide a method to compare relative differences among the six counties and Arizona.

The primary care practitioner's ratios include both primary care physicians and mid-level practitioners, in which nurse practitioners and physician assistants are counted as 0.8 FTE of a physician's FTE. There are higher population-to-primary care practitioner ratios in all six counties (Yavapai - 896:1 to Pinal - 1,436:1) than the state ratio of 785:1. Of the six counties, five have higher population-to-dentist ratios (Mohave - 2852:1 to La Paz -

9,910:1) than the state (2,120:1). All three demonstration counties have higher population-to-dentist ratios than the state (2,854:1 to 5,428:1).

Pinal County has the worst of all six counties in the ratio of population-to-number of pharmacies. In that county, there are 9,260 persons per pharmacy. The next two counties with worst population-per-pharmacies are Graham County (6,849:1) and La Paz County (6,607:1). The other three counties each fares better than the state's 5,885 persons-per-pharmacy.

Table 6 Selected Health Care Resources: Six RMCC Counties and Arizona, 1999

Health Resources	Cochise	Graham	Pinal	*La Paz*	*Mohave*	*Yavapai*	Arizona
Non-Federal Hospital	5	1	1	1	3	2	62
Hospital Beds / 1,000 Residents	1.65	1.23	0.92	2.03	1.32	2.09	2.08
Community-Based Primary Care Clinics	1	0	1 + 4 satellites	0	1	1	32 + 90 satellites
Primary Care Physicians (MD/DO)	73	16	67	6	83	102	NA
Population / Primary Care Physicians[1]	1,646:1	2,140:1	2,349:1	3,303:1	1,718:1	1,455:1	NA
Nurse Practitioners	36	7	26	3	28	47	1,772
Physician Assistants	19	8	23	2	34	19	658
Midwives	2	1	2	0	3	10	203
Population / Primary Care Providers	997:1	1,233:1	1,436:1	1,013:1	937:1	896:1	785:1
Dentists	31	12	29	2	50	84	2,284
Population / Dentists[2]	3,877:1	2,854:1	5,428:1	9,910:1	2,852:1	1,767:1	2,120:1
Pharmacies	23	5	17	3	25	26	823
Pop. / Pharmacies[2]	5,225:1	6,849:1	9,260:1	6,607:1	5,704:1	5,709:1	5,885:1

Sources: Arizona Department of Health, Bureau of Health Systems Development, Primary Care Area Statistics Profiles.
Arizona Association of Community Health Centers (Community-Based Primary Care Clinics).
Arizona State Board of Medical Examiners (MDs) and Arizona Osteopathic Medical Association (DOs).

[1] Calculation: Primary Care Doctors provided by 1999-2000 Medical Boards / 1999 County Population from DES.

[2] Calculation: Health Resources Numbers provided by 1999 PCA data / 1999 County Population from DES.

The three comparison counties are *italicized.*

HEALTH CARE FINANCING

Health Care Expenditure Overview

In 1998, the Health Care Financing Administration reported that the U.S. health care expenditure increased 5.6 percent from 1997 to $1.14 trillion, which is 13.5 percent of the gross domestic product.[4] Forty-five percent (45.4%) of the U.S. health care expenditures were paid by the public sector (Medicare - 18.8%, Medicaid - 14.8%, and other public programs - 11.8%). Of the 54.6 percent paid by the private sector ($626.4 billion), $375 billion (about 60%) was spent on private insurance premiums. Health insurance premiums increased more than twice in 1998 (8.2%) than in 1997 (3.5%). In 1998, employees covered by managed care ,e.g., HMO (Health Maintenance Organization), PPO (Preferred Provider Organization), and POS (Point of Service) plans accounted for 86 percent of all insured workers -- up from 54 percent in 1993.[5]

One of the major barriers to primary care and preventive services is the ability to pay for health services. Health insurance can provide the means to affordable health care. The number of Americans and Arizonans under the age of 65 without health insurance has been increasing during the past five years. At the end of 1998, 43.9 million (18.3%) Americans under the age of 65 had no insurance.[6] Arizona is among 11 states with more than 20 percent of their population under 65 years and 24.2 percent lacking health insurance. The sizable proportion of uninsured Arizonans is a major economic issue for this state. In 1991, Arizona hospitals reported providing more than $226 million in uncompensated care, a 6 percent increase over the prior year. AHCCCS, the state's Medicaid program, had its enrollment grow by 14 percent, more than 56,000 persons, between September 1991 and September 1992.[7]

Managed Care Enrollment

There is no universally accepted managed care terminology. For the purposes of this project, the term "managed care" refers to "financing and delivery systems that provide health care services within a defined network of health care providers who are given the responsibility to manage and provide quality, cost-effective health care"[8]; e.g., HMO, PPO, POS and PHO (Physician Hospital Organization) plans.[9,10] In 1995, more than 70 percent of Arizonans received their health care from a managed care organization as reported by the 1997 Arizonans and Managed Care Study.[11] Of those enrolled in Managed Care Organizations (MCOs), 59 percent are HMO members; 33 percent are PPO members, and the remaining 8 percent belong to other types of managed care plans.

Most of the growth of managed care organizations has occurred in urban areas. There has been penetration of rural commercial, Medicare, and Medicaid markets by HMOs and prepaid health plans. Although most rural counties include a managed care service area with at least one commercial HMO (in 1988, 52.6% of the rural counties had at least one commercial HMO; the number increased to 82.3% rural counties in 1995), rural HMO

enrollment rates are still very low compared to urban rates.[12] However, Arizona has been successful in expanding managed care (commercial, Medicare, and Medicaid) into its rural counties.

Moving from indemnity plans to managed care saves money. For example, a Foster Higgins study showed U.S. employers' total health plan costs decreased an average of 1.1 percent in 1994. According to the study, PPOs cost about 6 percent less than traditional indemnity plans, and HMOs (both pure and POS) cost about 7 percent less in 1994.[17]

Commercial Managed Care: The 1998 HMO national enrollment figures rose 18.3% to 105.3 million members from 89.0 million in 1997.[13] Nearly 28 million enrollees, or 26.5 percent of the total HMO membership, were covered in open-ended (OE) and point-of-service (POS) plans.[13] Arizona is in the top ten states in HMO penetration rates and has a higher penetration rate (47.8%) than the U.S. penetration average of 38.8 percent in 1998. Table 7 summarizes the Arizona HMO enrollment for 1994 to 1998. There has been an increase of 47.6 percent in enrollments (411,102) during the five-year period.

The HMO industry has undergone a wave of national consolidations in recent years. This also has impacted the state of Arizona (see Table 7 for details). The most notable among the mergers were United HealthCare and MetraHealth (1995), PacifiCare Health Systems and FHP International (1996), and Aetna Life and Casualty and U.S. Healthcare (1996).[14]

The second most popular type of managed care organization is the Preferred Provider Organization (PPO). An estimated 98.3 million eligible employees were covered by respondent medical/surgical and full-service PPOs in 1998 (up 10.3% from 89.1 million in 1997).[13] In 1998, Arizona had 62 owned networks and another 20 by contractual relationships.

Medicaid Managed Care: Medicaid, a joint federal-state health care financing and delivery system for the poor that was developed first with a consumer concern for access and later with cost containment objectives, has grown rapidly in managed care enrollment.[15] By 1998, 36 million people were covered by Medicaid at a cost of $170.8 billion, an increase of 6.6 percent over the 1997 level. The total number of Medicaid recipients enrolled in managed care organizations nationwide increased to 15.8 million in 1998 from 12.8 million in 1996.[13] The 10 states with the highest Medicaid MCO penetration rates together accounted for 3,574,550 Medicaid MCO members, or 22.7 percent of the total Medicaid recipients enrolled in MCOs nationwide. The top five Medicaid MCO states (penetration percent) are Tennessee (100%), Arizona (85.1%), New Mexico (83.1%), Hawaii (80.5%), and Utah (77.9%).[13] In May 1997, more than half of the U.S. rural counties were covered by some type of Medicaid managed care programs compared to nearly three-fourths of urban counties.[16]

In Arizona, all Medicaid beneficiaries are under managed care plans financed and monitored by Arizona Health Cost Containment System (AHCCCS), operated under a

Table 7 Arizona Health Maintenance Organization Enrollments: 1994-98

Health Maintenance Organization	1994	1995	1996	1997	1998
Aetna Health Plans of Arizona, Inc.	24,689	30,245	40,782	54,696	71,772
Cigna Healthcare of Arizona, Inc.	191,855	214,914	205,404	199,576	212,490
FHP, Inc.[3]	174,991	171,399	185,131	0	0
First Health of Arizona, Inc.	1,045	1,009	932	869	689
Humana Health Plan, Inc.	39,585	661,943	43,746	47,815	45,387
Intergroup Prepaid Health Services[1]	272,047	307,423	**********	**********	**********
Intergroup of Arizona, Inc. (96)[1]	**********	**********	325,733	335,128	336,085
Metlife Healthcare Network of Ariz.	8,309	14,285	**********	**********	**********
Partners Health Plan of Arizona[2]	102,460	116,128	**********	**********	**********
HealthPartners Health Plan (96)[2]	**********	**********	209,024	252,928	280,067
Samaritan Health Plan, Inc.	49,030	56,506	**********	**********	**********
University Physicians HMO, Inc.	0	0	0	0	0
Premier Healthcare of Arizona (95)	**********	1,451	21,496	32,881	58,607
Health Plan of Nevada, Inc. (96)	**********	**********	0	4,915	5,453
United Healthcare of Arizona (96)	**********	**********	22,536	45,041	62,569
Mayo Health Plan Arizona (97)	**********	**********	**********	0	8,384
PacifiCare of Arizona, Inc. (97)[3]	**********	**********	**********	198,185	193,610
One Health Plan of Arizona (98)	**********	**********	**********	**********	0
Total HMO Enrollment	864,011	1,575,303	1,054,784	1,172,034	1,275,113

Source: Annual Report of the Arizona Department of Insurance: 1994-1998
1,2, and 3 indicate changes of enrollees in managed care organizations.[14]

federal 1115 Research and Demonstration Waiver, since the program began in 1982. As of December 1, 1999, AHCCCS had 434,284 enrollees in Arizona under six health plans in Maricopa County, five health plans in Pima County, two health plans in Yuma County (urban), and two health plans in each set of paired rural counties. Table 8 provides a summary of the AHCCCS acute care enrollment for the six RMCC counties and Arizona over a six-year period (1994-99). The three demonstration counties had higher AHCCCS population enrollment percentages than the state percentages. For the three comparison counties, La Paz also had higher AHCCCS population enrollment percentages than the state percentages; Yavapai had lower population enrollment percentages than the state's;

Table 8 AHCCCS Enrollment for the Six RMCC Counties and Arizona, 1994-99

County/Year	County Population Estimate*	AHCCCS Annual Average Enrollment**	Pop. Enrollment Percentage
Cochise			
1994	108,225	14,341	13.3%
1995	112,000	14,076	12.6%
1996	114,925	14,347	12.5%
1997	119,650	14,383	12.0%
1998	118,492	12,782	10.8%
1999	120,179	13,490	11.2%***
Graham			
1994	30,625	4,672	15.3%
1995	30,050	4,517	15.0%
1996	31,150	4,719	15.1%
1997	32,575	4,663	14.3%
1998	33,263	4,299	12.9%
1999	34,245	4,761	13.9%***
Pinal			
1994	132,225	20,258	15.3%
1995	139,000	19,057	13.7%
1996	144,150	18,250	12.7%
1997	150,375	18,249	12.1%
1998	153,079	15,613	10.2%
1999	157,413	17,406	11.1%***

Sources: * Arizona Dept. of Economic Security Research Administration, Population Statistical Unit.
** Arizona Health Care Cost Containment System, Director's Office.
*** Includes enrollment in KidsCare (Arizona's Children's Health Insurance Program (CHIP)).
The three comparison counties are *italicized.*

Table 8 AHCCCS Enrollment for RMCC Counties and Arizona, 1994-99 (Cont.)

County/Year	County Pop.Estimate*	AHCCCS Avg. Enroll.**	Pop. Enroll. %
La Paz			
1994	*16,075*	*2,350*	*14.6%*
1995	*16,700*	*2,390*	*14.3%*
1996	*18,200*	*2,195*	*12.0%*
1997	*17,625*	*2,263*	*12.8%*
1998	*19,310*	*1,999*	*10.4%*
*1999****	*19,821*	*2,082*	*10.5%*
Mohave			
1994	*120,325*	*12,887*	*10.7%*
1995	*125,150*	*13,489*	*10.8%*
1996	*127,700*	*14,252*	*11.2%*
1997	*133,550*	*14,619*	*10.9%*
1998	*137,628*	*14,835*	*10.8%*
*1999****	*142,600*	*16,792*	*11.8%*
Yavapai			
1994	*123,500*	*9,675*	*7.8%*
1995	*130,300*	*9,873*	*7.6%*
1996	*134,600*	*10,635*	*7.9%*
1997	*142,075*	*11,096*	*7.8%*
1998	*143,942*	*9,629*	*6.7%*
*1999****	*148,428*	*11,322*	*7.6%*
Arizona			
1994	4,071,650	444,532	10.9%
1995	4,307,150	431,226	10.0%
1996	4,462,300	439,162	9.8%
1997	4,600,275	455,573	9.9%
1998	4,722,097	405,711	8.6%
1999	4,842,987	434,284	9.0%

and Mohave's population enrollment percentages, compared to the state, fluctuated -- sometimes higher and sometimes lower.

The AHCCCS population acute care enrollments had declined in all counties from 1994 to 1998 except in Mohave, which had shown no change in population enrollment status at the end of the five-year period. These declining enrollment patterns are similar to the state patterns.

Among the six counties, Pinal County had the largest decrease in population enrollment from 15.3 percent to 10.2 percent in these years. In 1999, all six counties had AHCCCS population increases due to KidsCare (Arizona's Children Health Insurance program - CHIP). On September 18, 1998, the AHCCCS KidsCare Title XXI State Plan was approved. The program began enrolling members on November 1, 1998, and Table 8's 1999 figures include KidsCare enrollments.

In Arizona, the AHCCCS acute care program produced savings on an average of 11 percent per year on medical costs, and 7 percent on both medical and administrative costs, over the first 11 years (FY 1983-93) compared to a traditional Medicaid program. Cost savings had grown from $10 million per year in the early years to approximately $72 million in FY 1993.[18,19] In 1994, AHCCCS provider health plans earned an aggregate of $56 million in profits, or 6.7 percent of gross income. According to a report by the U.S. General Accounting Office (GAO), "Arizona's capitation rates declined by 11 percent in 1994. Since its inception, the per-capita growth rate of Arizona's program has been less than the national per-capita growth rate for states with traditional Medicaid programs."[20,21]

Savings were generated from three sources: discounted rates accepted by providers; decreased emergency department utilization; and reductions in inpatient care.[22] Some critics of the managed care industry's savings said that the savings were "a result of enrollment practices, such as admitting healthy people, rather than cost-effective care,"[23] and that "as the money is squeezed from needed care, quality of care is sacrificed."[24]

Medicare Managed Care: Medicare is the nation's largest federally financed health insurance program ($216.6 billion), which covered approximately 39 million Americans (38,824,855) in 1998. It provides health insurance to people aged 65 and over (33,802,038 - 87%), those who have permanent kidney failure and certain people with disabilities (5,022,817 - 13%).[25] Since the early 1990s, the Medicare population enrolled in HMOs (Medicare + Choice Program) has grown steadily (100 Medicare HMOs in 1993 to 310 HMOs in 1999).[26] The number of Medicare beneficiaries enrolled in HMOs rose 16.9 percent in 1998, to 6.5 million from 5.6 million in 1997.

Arizona had the second highest penetration of HMOs into the Medicare beneficiary population at 41.8 percent.[27] Table 9 shows the six RMCC counties' trends in Medicare eligibility, HMO penetration in Medicare, and the Medicare AAPCC rates for 1993 to 1999.

Table 9 Total Medicare Eligibles, HMO Medicare Enrollment, and AAPCC for the Six RMCC Counties, 1993-99

County/Year	Eligible Population	HMO Members	Penetration %	AAPCC Rate
Cochise				
1993	15,194	259	2%	$321.21
1994	15,768	1,681	11%	$336.81
1995	16,290	3,579	22%	$384.55
1996	16,966	4,914	29%	$398.93
1997	17,522	5,903	38%	$398.93
1998	17,920	5,177	30%	$406.91
1999	18,329	5,207	28%	$445.77
Graham				
1993	3,825	24	1%	$293.96
1994	3,945	580	15%	$306.39
1995	4,081	1,165	29%	$348.82
1996	4,149	1,551	37%	$370.97
1997	4,245	1,203	28%	$370.97
1998	4,270	1,221	29%	$378.39
1999	4,301	50	1%	$424.25
Pinal				
1993	19,615	4,282	22%	$407.30
1994	20,656	5,645	27%	$437.77
1995	21,517	7,260	34%	$491.83
1996	22,667	8,856	39%	$519.91
1997	23,625	10,426	44%	$519.91
1998	24,364	11,096	46%	$530.31
1999	25,473	11,089	44%	$551.74

Source: Health Care Financing Administration, Medicare Managed Care Penetration by State and County, December 31, 1993 - 1999.

Table 9 Total Medicare Eligibles, HMO Medicare Enrollment, and AAPCC for the Six RMCC Counties, 1993-99 (Cont.)

County/Year	Eligible Population	HMO Members	Penetration %	AAPCC Rate
La Paz				
1993	NA	NA	NA	$356.05
1994	NA	NA	NA	$367.16
1995	2,983	89	3%	$444.46
1996	3,189	168	5%	$459.40
1997	3,329	525	16%	$459.40
1998	3,485	426	12%	$468.59
1999	3,658	26	1%	$505.13
Mohave				
1993	25,072	561	2%	$393.37
1994	26,567	656	3%	$410.81
1995	28,045	2,955	11%	$447.82
1996	29,704	5,306	18%	$474.48
1997	30,817	9,261	30%	$474.48
1998	32,143	10,994	34%	$483.97
1999	33,536	629	2%	$522.27
Yavapai				
1993	28,865	378	1%	$277.16
1994	30,188	468	2%	$289.73
1995	31,227	451	1%	$325.30
1996	33,551	1,343	4%	$333.95
1997	33,450	3,993	12%	$333.95
1998	34,371	3,933	11%	$367.00
1999	35,620	453	1%	$401.61

Source: HCFA, Medicare Managed Care Penetration by State and County, December 31, 1993 - 1999.
NA = Not Available. The three comparison counties are *italicized.*

The state of California had the highest HMO penetration (45.3%), and Oregon followed Arizona, with 40.7 percent of penetration.

Unlike commercial and Medicaid managed care, most rural Medicare beneficiaries did not have access to managed care. Three out of four rural Medicare beneficiaries (73%) live in a county that is not served by any Medicare HMO; only one rural beneficiary in four (27%) lives in a county that is served by one or more HMOs, according to Families USA.[26] Only 10 percent live in a county that is served by two or more HMOs.

The HMO penetration rate for the total county Medicare eligibilities increased for five of the six RMCC counties from 1993 to 1997. All three demonstration counties and Mohave County had penetration rates greater than 25 percent. Even though the AAPCC rate had steadily increased in all six RMCC counties during 1993 to 1999, all the counties had lower HMO penetration rates in 1999 than 1997. In 1999, Pinal County (44%) and Cochise County (28%) had the highest HMO penetration rates. The other four counties had penetration rates less than 3 percent in 1999.

It is anticipated that the national HMO Medicare enrollment trend increases seen during the 1990s will be decreasing as HMOs and MCOs coverage reduces and withdraws from rural areas. This decreasing trend has begun in Arizona and can be seen in Table 9 for all six RMCC counties. In 1999, there were 10 Medicare HMOs in Arizona. Of the 10, five had withdrawn and terminated their Medicare HMO coverage from selected areas in the state by the end of 1999.[27] The five Medicare HMOs that had terminated coverage in the six RMCC counties were: Blue Cross Blue Shield of Arizona and Health Plan of Nevada, which terminated all Medicare HMO coverage in Arizona; Human Health Plan in Pinal County except Apache Junction; Premier Healthcare of Arizona in Graham County; and United Healthcare of Arizona in Apache Junction, Pinal County.

For Graham County, this was the second major withdrawal by Medicare HMOs -- the first was the previous year when Intergroup of Arizona Senior and Health Partners Health Plan Senior pulled out of the county. The RMCC staff assisted Graham County by facilitating the discussion with Premier Healthcare of Arizona to replace both Intergroup and Health Partners Medicare HMOs. The Medicare HMO enrollment for March 1998 had dropped to 94 seniors as the result of the withdrawal of the two plans, but came back up to 1,221 when Premier Healthcare replaced the two plans in December 1998. As the result of Premier Healthcare going out of business, only 50 seniors were enrolled in Medicare HMOs at the end of 1999.

The reduction of coverage to and withdrawal from rural areas continued in 2000. There are seven remaining Medicare HMOs in the state.[28] Intergroup of Arizona will terminate Medicare HMO coverage in Cochise that will leave the county without a Medicare managed care plan and southern Pinal County on December 31, 2000. PacifiCare of Arizona will also terminate coverage in southern Pinal County in December 2000. However, both Intergroup of Arizona and PacifiCare of Arizona plan to stay in Pinal County.

Premium Sharing Program: On February 1, 1998, a state-funded, three-year Premium Sharing Pilot Program (PSP) was implemented.[29] To qualify for PSP, the applicant must have been without health insurance for a minimum of six months, not be a Medicaid, Medicare, or Veteran's Administration recipient and have a gross income of less than 200% FPL. The state subsidized the health care insurance premiums, which were based on the household's income, using Tobacco Tax revenues. The program only is available in two rural counties: Cochise and Pinal, and two urban counties: Maricopa and Pima. Health services are provided through three of AHCCCS' existing health plans and are administered through Healthcare Group, the state-administered program providing affordable health care options for small business. The RMCC staff had worked with both Cochise and Pinal County to enroll families into PSP. The results of the PSP efforts are shown in Table 10. The PSP Cochise (11.9%) and Pinal (7.8%) enrollments exceeded the projected county targets of 4.7 and 5.1 percents, respectively.

Managed Care Payment

In the 12 rural counties, there are two AHCCCS managed care plans for each paired counties (e.g., Cochise and Santa Cruz Counties). Table 11 summarizes the 1999-2000 capitation rates for each of the two acute care health plans for the six RMCC counties. Under the TANF coverage, infants (< 1 y/o) received the highest capitation rate while those between 1 and 13 years of age received the lowest rate. For those 14 to 44 years of age, males received lower capitation rates than females. Tables 12 and 13 summarize the counties' financial contribution to AHCCCS and average county dollar payment per Acute Care AHCCCS enrollment. Pinal (4.07%) and Cochise (3.32%) paid the highest percent of county contribution to AHCCCS, while La Paz paid the lowest percent of 0.32 percent. During the five-year period (1996 to 1998), Cochise paid the highest average dollar payment per AHCCCS enrollee.

Table 10 Four-County Premium Sharing Program Summary, Jan. 1998 to July 2000

County	July 98	Jan. 99	July 99	Jan 00	July 00	Actual %	Project %
Rural							
Cochise	133	321	638	715	782	11.9%	4.7%
Pinal	159	246	325	363	508	7.8%	5.1%
Urban							
Maricopa	657	1,397	2,133	2,764	3,117	47.6%	67.7%
Pima	556	943	1,364	1,787	2,144	32.7%	22.5%
Total	1,505	2,907	4,460	5,629	6,551	********	********

Source: AHCCCS Premium Sharing Administration

Table 11 AHCCCS Capitation Rates for Acute Care Health Plans for the Six RMCC Counties, October 1, 1999 through September 30, 2000

Coverage Category	Cochise County APIPA	Cochise County MCare	Graham County APIPA	Graham County MCare	Pinal County ComCon	Pinal County MCare
TANF <1y/o M/F	$319.38	$319.38	$321.67	$321.67	$322.19	$307.58
TANF 1-13 y/o M/F	$ 68.65	$ 68.65	$ 68.46	$ 73.33	$ 64.35	$ 67.53
TANF 14-44 y/o F	$127.64	$120.66	$129.75	$116.18	$117.19	$123.30
TANF 14-44 y/o M	$ 93.22	$ 92.28	$ 94.68	$ 92.12	$ 89.45	$ 88.44
TANF 45+ y/o M/F	$213.09	$215.47	$212.98	$212.98	$225.14	$218.12
SSI w / Med	$143.72	$147.71	$144.16	$147.80	$144.50	$147.89
SSI wo / Med	$307.52	$296.66	$309.76	$308.12	$321.50	$311.36
MN/MI	$455.73	$455.73	$458.74	$458.74	$428.26	$428.26
SFP	$ 23.14	$ 23.14	$ 22.96	$ 22.96	$ 19.69	$ 19.69
SOBRA KICK	$4,907.04	$4,801.65	$4,935.88	$4,943.53	$5,037.67	$4,893.82
Coverage Category	***La Paz County APIPA***	***La Paz County AzHCon***	***Mohave County APIPA***	***Mohave County AzHCon***	***Yavapai County APIPA***	***Yavapai County MCare***
TANF <1y/o M/F	$332.42	$350.10	$332.42	$350.10	$318.32	$318.32
TANF 1-13 y/o M/F	$ 72.96	$ 67.20	$ 72.96	$ 67.20	$ 65.40	$ 67.88
TANF 14-44 y/o F	$130.72	$117.53	$130.72	$117.53	$123.25	$121.41
TANF 14-44 y/o M	$ 97.62	$ 91.21	$ 97.62	$ 91.21	$ 93.03	$ 89.30
TANF 45+ y/o M/F	$220.02	$212.31	$220.02	$212.31	$210.46	$220.13
SSI w / Medicare	$153.42	$151.88	$153.42	$151.88	$146.54	$149.82
SSI wo / Medicare	$319.11	$306.00	$319.11	$306.00	$316.15	$305.36
MN/MI	$500.87	$479.21	$500.87	$479.21	$450.82	$483.22
SFP	$ 24.34	$ 22.14	$ 24.34	$ 22.14	$ 20.67	$ 20.67
SOBRA KICK	$5,021.18	$5,009.69	$5,021.18	$5,009.69	$5,030.58	$4,920.91

Source: AHCCCS Web Site: http://www.ahcccs.state.az.us/services/acute;capgsa6.htm
The three comparison counties are *italicized.*

Table 12 Total Financial Contribution to AHCCCS Acute Care for the Six RMCC Counties, 1994-98

County (Percent)	1994	1995	1996	1997	1998
Cochise (3.32%)	2,586,534	2,460,841	2,214,758	2,214,758	2,214,758
Graham (0.80%)	626,189	595,759	536,184	536,184	536,184
Pinal (4.07%)	3,171,445	3,017,328	2,715,596	2,715,596	2,715,596
La Paz (0.32%)	*247,672*	*235,636*	*212,073*	*212,073*	*212,073*
Mohave (1.86%)	*1,445,531*	*1,375,285*	*1,237,757*	*1,237,757*	*1,237,757*
Yavapai (2.14%)	*1,667,501*	*1,586,468*	*1,427,822*	*1,427,822*	*1,427.822*

Source: County Supervisor Association.
The three comparison counties are *italicized.*

Table 13 Average Dollar Amount Payment per AHCCCS Enrollee: Acute Care for the Six RMCC Counties, 1994-98

County	1994	1995	1996	1997	1998
Cochise	150.32	180.36	174.83	154.37	154.98
Graham	109.90	134.03	131.89	113.62	114.99
Pinal	126.67	156.55	158.33	148.80	148.81
La Paz	*84.16*	*105.39*	*98.60*	*91.62*	*93.71*
Mohave	*99.47*	*112.17*	*101.96*	*86.85*	*84.67*
Yavapai	*141.52*	*172.35*	*106.69*	*134.26*	*128.68*

Source: County Supervisor Association.
Calculation based on total county AHCCCS dollars divided by total yearly average enrollment
The three comparison counties are *italicized.*

In Arizona, Title XIX (Medicaid) Mental Health Services are provided by the Arizona Department of Health Services -- carved out from the acute care provided by AHCCCS. There are five Regional Behavioral Health Authorities responsible for the monitoring and contracting of mental health services in the state. These services are paid by capitation rates established by the Arizona Department of Health Services. Table 14 summarizes the 1997 and 2000 capitation rates for three types of mental health services: Children's Mental Health Services, Severe Mental Illness, and General Mental Health and Substance Abuse. For all six RMCC counties in 1997 and 2000, General Mental Health and Substance Abuse received the lowest capitation rate, while Severe Mental Illness received the highest rate. There were significant capitation rate increases for all three types of mental health services in 2000 from 1997.

Table 14 Capitation Rates for Mental Health Services: Children, Severe Mental Illness, and General Mental Health and Substance Abuse for the Six RMCC Counties, 1997 and 2000

County	Children		Severe Mental Illness		General Mental Health and Substance Abuse	
	1997	2000	1997	2000	1997	2000
Cochise	$18.22	$18.71	$34.09	$48.88	$ 2.87	$12.15
Graham	$18.22	$18.71	$34.09	$48.88	$ 2.87	$12.15
Pinal	$20.48	$21.53	$30.15	$48.79	$ 7.01	$12.73
La Paz	*$ 9.81*	*$15.29*	*$18.53*	*$41.15*	*$ 6.60*	*$10.10*
Mohave	*$10.65*	*$21.53*	*$17.21*	*$42.46*	*$ 3.79*	*$12.37*
Yavapai	*$10.65*	*$21.53*	*$17.21*	*$42.46*	*$ 3.79*	*$12.37*

Source: Arizona Department of Health Services, Behavioral Health Systems.
The three comparison counties are *italicized*.

Sources of Payment for Health Care

This section will examine the sources of payment for three types of health care (e.g., delivery of babies, prenatal care, and hospital care). Table 15 provides a summary of births by source of payment type for the six RMCC counties during a five-year period (1994 to 1998). AHCCCS was the primary payer of births for all six RMCC counties during the five-year period. In 1998, the three demonstration counties had a greater number of births paid by private insurance than the three comparison counties. For the entire the five-year period, Cochise County had a greater number of births paid by private insurance than the other five counties.

Table 15 Total Births and Source of Payment for the Six RMCC Counties, 1994-98

County/Year	Total	AHCCCS	IHS	Private Ins.	Self Pay	Unknown
Cochise						
1994	1,702	739 (43.4%)	6 (0.4%)	834 (49.0%)	56 (3.3%)	67 (3.9%)
1995	1,755	820 (46.7%)	7 (0.4%)	846 (48.2%)	62 (3.5%)	20 (1.1%)
1996	1,726	776 (45.0%)	9 (0.5%)	854 (49.5%)	69 (4.0%)	18 (1.0%)
1997	1,650	757 (45.9%)	4 (0.2%)	814 (49.3%)	62 (3.8%)	13 (0.8%)
1998	1,633	738 (45.2%)	1 (0.1%)	807 (49.4%)	67 (4.1%)	20 (1.2%)
Graham						
1994	417	228 (54.7%)	27 (6.5%)	136 (32.6%)	12 (2.9%)	14 (3.4%)
1995	397	205 (51.6%)	29 (7.3%)	144 (36.2%)	16 (4.0%)	3 (0.8%)
1996	471	236 (50.1%)	47 (10.0%)	163 (34.6%)	13 (2.8%)	12 (2.5%)
1997	491	234 (47.7%)	38 (7.7%)	200 (40.7%)	15 (3.1%)	4 (0.8%)
1998	488	243 (49.8%)	39 (8.0%)	198 (40.6%)	7 (1.4%)	1 (0.2%)
Pinal						
1994	2,041	1,101 (54.0%)	166 (8.1%)	610 (29.9%)	73 (3.6%)	91 (4.5%)
1995	2,029	1,105 (54.5%)	142 (7.0%)	673 (33.2%)	60 (3.0%)	49 (2.4%)
1996	2,110	1,106 (52.4%)	126 (6.0%)	788 (37.3%)	52 (2.5%)	38 (1.8%)
1997	2,150	1,152 (53.6%)	120 (5.6%)	786 (36.6%)	40 (1.9%)	52 (2.4%)
1998	2,231	1,227 (55.0%)	21 (0.9%)	889 (39.9%)	49 (2.2%)	45 (2.0%)

Source: Arizona Department of Health Services, Arizona Health Status and Vital Statistics, 1994-98. The three comparison counties are *italicized.*

Table 15 Total Births and Source of Payment for the Six RMCC Counties, 1994-98 (Cont.)

County/Year	Total	AHCCCS	IHS	Private Ins.	Self Pay	Unknown
La Paz						
1994	*222*	*128 (57.7%)*	*7 (3.2%)*	*25 (11.3%)*	*6 (2.7%)*	*56 (25.2%)*
1995	*191*	*95 (49.7%)*	*1 (0.5%)*	*37 (19.4%)*	*3 (1.6%)*	*55 (28.8%)*
1996	*152*	*111 (73.0%)*	*1 (0.7%)*	*32 (21.1%)*	*2 (1.3%)*	*6 (3.9%)*
1997	*200*	*104 (52.0%)*	*1 (0.5%)*	*63 (31.5%)*	*4 (2.0%)*	*28 (14.0%)*
1998	*169*	*98 (58.0%)*	*1 (0.6%)*	*37 (21.9%)*	*5 (3.0%)*	*28 (16.6%)*
Mohave						
1994	*1,863*	*931 (50.0%)*	*3 (0.2%)*	*561 (30.1%)*	*110 (5.9%)*	*258 (13.8%)*
1995	*1,841*	*928 (50.4%)*	*7 (0.4%)*	*591 (32.1%)*	*100 (5.4%)*	*215 (11.7%)*
1996	*1,816*	*912 (50.2%)*	*6 (0.3%)*	*647 (35.6%)*	*86 (4.7%)*	*165 (9.1%)*
1997	*1,763*	*831 (47.1%)*	*4 (0.2%)*	*661 (37.5%)*	*80 (4.5%)*	*187 (10.6%)*
1998	*1,678*	*773 (46.1%)*	*4 (0.2%)*	*593 (35.3%)*	*68 (4.1%)*	*240 (14.3%)*
Yavapai						
1994	*1,377*	*753 (54.7%)*	*7 (0.5%)*	*449 (32.6%)*	*114 (8.3%)*	*54 (3.9%)*
1995	*1,532*	*823 (53.7%)*	*8 (0.5%)*	*499 (32.6%)*	*168 (11.0%)*	*34 (2.2%)*
1996	*1,576*	*866 (54.9%)*	*7 (0.4%)*	*531 (33.7%)*	*150 (9.5%)*	*22 (1.4%)*
1997	*1,546*	*801 (51.8%)*	*0 (0.0%)*	*591 (38.2%)*	*119 (7.7%)*	*35 (2.3%)*
1998	*1,693*	*861 (50.9%)*	*0 (0.0%)*	*672 (39.7%)*	*132 (7.8%)*	*28 (1.7%)*

Source: Arizona Department of Health Services, Arizona Health Status and Vital Statistics, 1994-98. The three comparison counties are *italicized.*

Table 16 provides a summary of the average number of prenatal visits during pregnancy by type of payment for the six RMCC counties in 1998. Private insurance (including managed care) had the highest average prenatal visits. Both AHCCCS and Indian Health Service mothers had prenatal visit averages lower than the overall county averages. Of the six counties, Cochise had the highest prenatal visit average under private insurance, while La Paz had the lowest prenatal visit average under self-pay.

Tables 17, 18 and 19 summarize the 1996 payment profile for hospital care for the six RMCC counties. Of the six counties, Pinal had the highest hospital expenditure dollars ($216,664,028 for 18,596 discharges), while La Paz had the lowest ($24,917,371 for 1,961 discharges). La Paz also had the highest average day stay (4.5 days) and average charges per discharge ($12,706).

There were significant hospital dollars leaving the six counties. The amount of dollars leaving the counties ranged from 36.0 percent in Mohave to 82.4 percent in Pinal. However, the percent of out-of-county hospital admissions (63.3%) for Pinal residents was less than the percent of hospital dollars leaving the county (82.4%). For the other five counties, the same pattern existed -- higher percent of hospital dollars leaving the county than percent of hospital admissions.

HEALTH CARE RESOURCE UTILIZATION

In reviewing the available data, the RMCC staff determined that county level data on access to primary care and preventive services was quite limited. This section compares the prenatal care use, immunization coverage, and hospitalization rate for the three RMCC demonstration and three comparison counties.

National studies examine the use of health services between managed care plans and other payment methods and/or health care delivery systems. For example, a national study of managed care plans reported that there were either higher rates or little differences in HMO plan office visits per enrollee compared with indemnity plans. However, compared with indemnity plans, hospital admission rates were lower among HMO enrollees, and the lengths of stay were shorter.[9]

In Arizona, the Flinn Foundation's 1989 and 1995 surveys found that 46 and 47 percents, respectively, of adult AHCCCS patients reported fair or poor health, compared to only 15 percent of those with other types of insurance.[20] The use of health services by AHCCCS enrollees also reflects the poorer health status of the AHCCCS population. Table 20 provides the comparison of health care utilization between AHCCCS enrollees and those with other insurance.[20] In 1995, AHCCCS patients visited a doctor twice as often as those with other types of insurance (average of 17 annual visits versus eight). AHCCCS enrollees used more than twice as many hospital services during the past 12 months as other insurance programs.

Table 16 Average Number of Prenatal Visits During Pregnancy by Sources of Payment Type for the Six RMCC Counties, 1998*

County of Residence	County Average	AHCCCS Average	IHS Average	Private Ins. Average	Self Pay Average
Cochise	11.8	11.1	9.0	12.6	9.8
Graham	10.0	9.5	9.6	10.7	8.0
Pinal	10.1	9.5	9.7	11.1	10.3
La Paz	*8.9*	*9.0*	*10.0*	*11.3*	*6.2*
Mohave	*10.2*	*9.7*	*7.5*	*11.6*	*8.4*
Yavapai	*10.1*	*9.3*	*NA*	*11.0*	*10.5*

*Source: Arizona Department of Health Services, Arizona Health Status and Vital Statistics 1998.
The three comparison counties are *italicized.*

Table 17 Payment for Hospital Care for the Six RMCC Counties, 1996

County of Residence	Discharges	Total Charges	Avg Charge /Discharge	Total Days	Average Stay
Cochise	12,070	$ 119,287,380	$ 9,882.96	45,913	3.8
Graham	4,318	$ 40,658,373	$ 9,416.02	16,285	3.8
Pinal	18,596	$ 216,664,028	$ 11,651.11	75,892	4.1
La Paz	*1,961*	*$ 24,917,371*	*$ 12,706.46*	*8,891*	*4.5*
Mohave	*14,872*	*$ 167,548,602*	*$ 11,266,04*	*59,826*	*4.0*
Yavapai	*14,334*	*$ 168,925,023*	*$ 11,784.92*	*55,375*	*3.9*

Source: ADHS, Public Health Services, Office of Health Planning, Evaluation and Statistics, Arizona Center for Health Statistics (http://www.hs.state.az.us/plan/cprofile/hosp/dschrg1.htm).
The three comparison counties are *italicized.*

Table 18 Hospital Care Provided Outside County for the Six RMCC Counties, 1996*

County of Residence	Total Admissions	Leaving County for Hospital Services %	Total Charges	Hospital Dollars Leaving County %
Cochise	12,133	4,590 (37.8%)	$ 120,334,295	$ 83,939,076 (69.8%)
Graham	3,626	1,297 (35.8%)	$ 31,812,107	$ 23,847,528 (75.0%)
Pinal	18,501	11,720 (63.3%)	$ 217,968,398	$179,616,874 (82.4%)
La Paz	*1,877*	*1,099 (58.6%)*	*$ 23,729,106*	*$ 19,065,253 (80.3%)*
Mohave	*15,383*	*2,190 (14.2%)*	*$ 171,824,075*	*$ 61,824,075 (36.0%)*
Yavapai	*13,120*	*3,723 (28.4%)*	*$ 152,108,088*	*$ 83,414,198 (54.8%)*

*Source: Arizona Department of Health Services, Office of Health Planning, Evaluation and Statistics, 1996 Hospital Discharge Data Tape.
The three comparison counties are *italicized.*

Table 19 Percentage of Hospital Care Provided Outside County by Managed Care Payment Type for the Six RMCC Counties, 1996*

County of Residence	Total Admissions	Total Percent	HMO Percent	PPO Percent	AHCCCS Percent	Medicare Risk Percent
Cochise	12,133	37.8%	71.2%	49.2%	48.0%	86.9%
Graham	3,626	35.8%	79.8%	60.1%	34.5%	81.4%
Pinal	18,501	63.3%	81.1%	89.8%	99.8%	41.3%
La Paz	*1,877*	*58.6%*	*63.9%*	*87.9%*	*86.2%*	*60.0%*
Mohave	*15,383*	*14.2%*	*24.9%*	*12.5%*	*32.8%*	*4.2%*
Yavapai	*13,120*	*28.4%*	*33.9%*	*11.2%*	*2.7%*	*96.2%*

*Source: Arizona Department Health Services, Office of Health Planning, Evaluation and Statistics, 1996 Hospital Discharge Data Tape.
The three comparison counties are *italicized.*

Those enrolled in AHCCCS were far more likely (1989 - 30% and 1995 - 40%) to have had a medical emergency than those with other types of insurance (1989 - 18% and 1995 - 15%).[20] This high use of emergency medical services by AHCCCS enrollees was also seen in the RMCC study of emergency room (ER) utilization patterns in Cochise and Pinal Counties. In 1996, the AHCCCS enrollees comprised 12.2 percent of the population in Cochise County and 14.0 percent in Pinal County. However, 31 percent of the ER users in Cochise County and 32 percent in Pinal County were AHCCCS enrollees.[30]

Table 21 summarizes the 1995 satisfaction levels of adult enrollees in AHCCCS, private managed care plans, and Medicare managed care plans.[20] For all three groups, the overall satisfaction level for their health insurance plan was above 75 percent. Medicare enrollees had the highest overall satisfaction level (85 percent). The lowest satisfaction levels were in waiting time to get a routine appointment (AHCCCS - 54%, Private MC - 61%, and Medicare MC - 82%) and waiting in the doctor's office for a routine visit (AHCCCS - 55%, Private MC - 57%, and Medicare MC - 80%).

Preventive Health Services

Table 22 summarizes prenatal care in the six RMCC counties and Arizona from 1994 to 1998. Prenatal care rate, started in the first trimester, increased during the five-year period in both demonstration and comparison counties, except in Cochise (Note: this did not include prenatal care that was obtained in Mexico). This increased first trimester prenatal care trend during the five-year period also occurred statewide. However, the six counties had lower first trimester prenatal care rates than the statewide rate for 1996 to 1998.

The Arizona Immunization Program Office reported the levels of immunization coverage based on information provided by county health departments and community health centers. Table 23 indicates that during the five years (1993 to 1997) rates fluctuated widely in all six counties. For example, Graham County's rate of infants who had completed the 4:3:1 immunization series by age 24 months increased from 45 percent in Fall 1993 to 71 percent in Fall 1994 and decreased to 66 percent in Fall 1995. The overall 4:3:1 series immunization rates have improved during the period of 1993 to 1997 in both demonstration and comparison counties except Mohave which remained the same at 55 percent in 1997. Of the six counties in 1997, Yavapai had the highest immunization rate at 80 percent and Mohave had the lowest rate at 55 percent.

Hospital Services

As expected, hospitalization rates increased with age in 1999, except for the 0-14 years of age group that had higher rates than those 15-19 years (refer to Table 24 for details). For all six counties, the highest users of hospital services were those 65 years of age and older. The most common diagnoses for seniors reported in 1995 were: heart failure, shock, joint and limb procedures, chronic obstructive pulmonary disease, pneumonia,

Table 20 Key Health Indicators: Comparing AHCCCS and Other Insurance Enrollees for 1989 and 1995

	AHCCCS enrollees		All other insurance*	
	1989	1995	1989	1995
Persons in fair or poor health	46%	47%	15%	15%
AHCCCS doctor easier to get to than prior provider	59%	59%	-	-
Persons with one or more doctor visits in past 12 months	76%	73%	69%	73%
Average number of visits (of those with visits)	16	17	9	8
Persons hospitalized in past 12 months	31%	26%	11%	8%
Persons with medical emergency in past 12 months	30%	40%	18%	15%

Source: The Flinn Foundation/Louis Harris. December, 1995. Arizona's Managed-Care Medicaid Program (AHCCCS).
*Includes conventional fee-for-service, managed care (HMO), and Medicare.

Table 21 Satisfaction Levels of Adult Enrollees for Arizona Managed Care, 1995

Satisfaction Category	AHCCCS	Private MC	Medicare MC
Your health insurance plan overall	76%	77%	85%
The waiting time to get a routine appointment	54%	61%	82%
The waiting time in a doctor's office for a routine visit	55%	57%	80%
The hours when offices or clinics are open	71%	70%	84%
The coverage of preventive care, such as check-ups, well-baby care, and routine office visits.	75%	77%	86%

Source: The Flinn Foundation/Louis Harris. December, 1995. Arizona's Managed-Care Medicaid Program (AHCCCS).

Table 22 Prenatal Care for the Six RMCC Counties and Arizona, 1994-98

Prenatal Care Indicators	County	1994	1995	1996	1997	1998
Percent of Prenatal Care Started in The First Trimester	Cochise	73.3%	76.8%	69.8%	71.5%	67.4%
	Graham	62.8%	61.2%	65.6%	67.2%	68.2%
	Pinal	64.1%	63.0%	66.8%	68.1%	67.1%
	La Paz	*48.6%*	*51.3%*	*66.8%*	*61.0%*	*56.8%*
	Mohave	*59.7%*	*63.4%*	*68.3%*	*72.4%*	*62.2%*
	Yavapai	*60.6%*	*64.4%*	*66.1%*	*69.0%*	*66.5%*
	Arizona	69.8%	70.7%	72.9%	74.4%	73.6%
Percent of Live Births With 0-4 Prenatal Care Visits	Cochise	5.0%	4.5%	7.5%	4.1%	4.7%
	Graham	9.4%	10.1%	6.6%	10.2%	8.8%
	Pinal	11.2%	9.3%	9.3%	8.1%	*8.3%*
	La Paz	*16.7%*	*15.7%*	*13.2%*	*10.0%*	*14.8%*
	Mohave	*14.4%*	*12.7%*	*8.2%*	*6.1%*	*8.5%*
	Yavapai	*9.7%*	*9.6%*	*5.9%*	*5.9%*	5.3%
	Arizona	7.4%	7.1%	6.8%	4.8%	5.0%

Source: Arizona Department of Health Services, Arizona Health Status and Vital Statistics, 1994-1998.
The three comparison counties are *italicized.*

Table 23 Public Health Immunization Coverage Levels for 26-35 Month Cohort* for the Six RMCC Counties, 1993-97

County	Fall '93	Fall '94	Fall '95	Fall '96	Fall '97
Cochise	50%	74%	86%	66%	73%
Graham	45%	71%	66%	74%	73%
Pinal	32%	46%	64%	55%	62%
La Paz	*45%*	*58%*	*80%*	*73%*	*76%*
Mohave	*55%*	*75%*	*82%*	*76%*	*55%*
Yavapai	*40%*	*62%*	*62%*	*67%*	*80%*

Source: Arizona Immunization Program Office, 1997. Assessments are conducted at County Health Departments and Community Health Centers. The Immunization Coverage Levels for Arizona are not available.
The three comparison counties are *italicized.*
* Immunization coverage is defined as 4 doses of DPT, 3 doses of polio and 1 dose of MMR by 24 months of age

Table 24 **Hospitalization: Inpatient days per 1,000 Residents by Age Groups for the Six RMCC Counties and Arizona, 1999**

County	All Age Groups	0-14 yrs	15-19 yrs	20-44 yrs	45-64 yrs	65-84 yrs	85+ yrs
Cochise	384	183	137	183	401	1,328	3,067
Graham	491	275	182	312	673	1,306	3,460
Pinal	525	246	200	265	627	1,561	5,401
La Paz	*509*	*166*	*160*	*250*	*627*	*1,154*	*2,429*
Mohave	*462*	*218*	*136*	*196*	*446*	*1,091*	*3,030*
Yavapai	*418*	*227*	*118*	*180*	*361*	*922*	*2,075*
Arizona	416	314	151	221	446	1,185	2,836

Source: Arizona Department of Health Services, PCA Statistical Profile.
* Does not include federal hospitals.
The three comparison counties are *italicized.*

pleurisy, and cerebrovascular disease.[31] All three demonstration counties had higher hospitalization rates for those 65 years of age and older than the state rate. However, two of the three comparison counties (La Paz and Yavapai) had lower hospitalization rates than the state rate for those 65 years of age and older.

HEALTH STATUS

The health status of the six RMCC counties will be examined in this section. Table 25 provides selected natality information for the six counties and Arizona. Among the demonstration counties, Pinal had the highest fertility rate for women 15 to 44 years of age during the five-year period from 1994 to 1998, while Yavapai County had the highest rate for the comparison counties. In 1998, La Paz County had the lowest fertility rate of 51.4 and Pinal County had the highest rate of 80.1.

During the five-year period, all six counties had lower birth rates than the state. However, for 1996 to 1998, the demonstration counties had higher birth rates than the comparison counties. Teenage pregnancy rates had declined in all six counties as well as the state since 1994. Graham County had the lowest reduction in teenage pregnancy rates (67.0 to 55.7), while Pinal County had the highest rate of reduction (118.0 to 86.8).

Table 25 Selected Natality Information for the Six RMCC Counties and Arizona: 1994-98

	County	1994	1995	1996	1997	1998
Female Population of Childbearing Age 15-44 Years	Cochise	21,235	21,768	22,654	22,816	22,947
	Graham	5,724	6,029	6,016	6,207	6,362
	Pinal	24,409	25,264	26,688	27,261	27,794
	La Paz	*2,758*	*2,901*	*3,732*	*3,240*	*3,286*
	Mohave	*18,879*	*20,805*	*20,868*	*21,396*	*21,912*
	Yavapai	*20,026*	*20,996*	*21,890*	*22,424*	*22,843*
	Arizona	895,518	906,742	971,606	992,919	1,010,667
Number of Births	Cochise	1,702	1,755	1,726	1,650	1,633
	Graham	417	397	471	491	488
	Pinal	2,041	2,029	2,110	2,150	2,231
	Mohave	*1,863*	*1,841*	*1,816*	*1,763*	*1,678*
	La Paz	*222*	*191*	*152*	*200*	*169*
	Yavapai	*1,377*	*1,532*	*1,576*	*1,546*	*1,693*
	Arizona	70,896	72,386	75,094	75,567	77,940
Fertility Rate Number of Births Per 1000 Women, Age 15-44 Years	Cochise	80.2	80.6	76.2	72.3	71.8
	Graham	72.9	65.9	78.3	79.1	76.7
	Pinal	83.6	80.3	79.1	78.9	80.3
	La Paz	*80.5*	*65.8*	*47.8*	*61.7*	*51.4*
	Mohave	*98.7*	*88.5*	*87.0*	*82.4*	*76.6*
	Yavapai	*68.8*	*73.0*	*72.0*	*68.9*	*74.1*
	Arizona	79.2	79.8	77.3	76.1	77.1
Birth Rate Number of Births Per 1000 Population	Cochise	16.3	16.0	15.0	14.1	13.8
	Graham	14.6	12.7	15.1	15.2	14.7
	Pinal	16.1	14.9	14.6	14.5	14.6
	La Paz	*14.5*	*11.6*	*8.4*	*10.7*	*8.8*
	Mohave	*16.5*	*14.6*	*14.2*	*13.3*	*12.2*
	Yavapai	*11.4*	*12.0*	*11.7*	*11.1*	*11.8*
	Arizona	17.6	17.3	16.8	16.4	16.5

Table 25 Selected Natality Information for RMCC Counties and Arizona, 1994-98 (Cont.)

	County	1994	1995	1996	1997	1998
Teenage Pregnancy Rate Number/1000 Females 15-19 Years	Cochise	78.2	71.2	73.8	64.2	59.0
	Graham	67.0	57.1	79.8	68.8	55.7
	Pinal	118.0	107.2	100.1	84.2	86.8
	La Paz	*90.0*	*88.6*	*58.2*	*62.4*	*66.4*
	Mohave	*98.0*	*97.1*	*91.5*	*72.1*	*64.2*
	Yavapai	*75.1*	*75.4*	*69.7*	*57.1*	*61.3*
	Arizona	102.0	96.1	91.3	77.1	80.3
Low Birth-Weight Number Under 2500 grams/1000 Births	Cochise	62.3	68.4	73.6	70.9	73.5
	Graham	105.5	63.0	68.0	73.3	63.5
	Pinal	76.0	67.6	73.5	69.8	75.8
	La Paz	*45.0*	*94.2*	*72.4*	*80.0*	*41.4*
	Mohave	*72.5*	*80.9*	*73.3*	*60.1*	*73.9*
	Yavapai	*84.2*	*73.8*	*64.1*	*69.9*	*78.0*
	Arizona	67.9	68.3	67.6	69.2	68.2
Infant Mortality Rate Per 1000 Live Births	Cochise	8.8	12.5	7.5	6.1	8.0
	Graham	9.6	12.6	17.0	8.1	4.1
	Pinal	10.8	7.4	5.7	9.8	9.9
	La Paz	*4.5*	*10.5*	*N/A*	*25.0*	*11.8*
	Mohave	*7.0*	*7.6*	*11.0*	*9.6*	*11.3*
	Yavapai	*7.3*	*7.8*	*8.2*	*5.2*	*10.6*
	Arizona	7.9	7.6	7.7	7.2	7.6

Source: Arizona Department of Health Services, Arizona Health Status and Vital Statistics, 1994-1998.
The three comparison counties are *italicized.*

Pinal County still has the highest teenage pregnancy rate of the six counties and was significantly higher than the state rate.

In 1998, five of the six counties had higher infant mortality rates than the state. Graham County (4.1) had significantly lower infant mortality rates than the state (7.6). In 1997-98, La Paz had the highest infant mortality rates of the six counties (25.0 in 1997 and 11.8 in 1998).

During 1996 through 1998, two out of three demonstration counties (Cochise and Pinal) had higher rates of low birth-weight births (< 2,500 grams) than the state. Table 26 summarizes the 1998 low birth-weight births by payment sources for the six counties.

Table 26 Low-Birth Weight Births by Payment Source for Six RMCC Counties, 1998

County of Residence	Total Births	AHCCCS	IHS	Private Insurance	Self-Pay
Cochise					
<2,500 g	118 (7%)	62 (8%)	0 (0%)	51 (6%)	5 (8%)
2,500+ g	1,492 (93%)	673 (92%)	1 (100%)	756 (94%)	62 (92%)
Total	1,610 (100%)	735 (100%)	1 (100%)	807 (100%)	67 (100%)
Graham					
<2,500 g	31 (6%)	22 (9%)	0 (0%)	8 (4%)	1 (14%)
2,500+ g	456 (94%)	221 (91%)	39 (100%)	190 (96%)	6 (86%)
Total	487 (100%)	243 (100%)	39 (100%)	198 (100%)	7 (100%)
Pinal					
<2,500 g	166 (8%)	105 (9%)	2 (10%)	55 (6%)	4 (8%)
2,500+ g	2,019 (92%)	1,122 (91%)	19 (90%)	833 (94%)	45 (92%)
Total	2,185 (100%)	1,227 (100%)	21 (100%)	888 (100%)	49 (100%)
La Paz					
<2,500 g	7 (5%)	6 (6%)	0 (0%)	0 (0%)	1 (20%)
2,500+ g	134 (95%)	92 (94%)	1 (100%)	37 (100%)	4 (80%)
Total	141 (100%)	98 (100%)	1 (100%)	37 (100%)	5 (100%)
Mohave					
<2,500 g	110 (8%)	65 (8%)	0 (0%)	37 (6%)	8 (12%)
2,500+ g	1,327 (92%)	707 (92%)	4 (100%)	556 (94%)	60 (88%)
Total	1,437 (100%)	772 (100%)	4 (100%)	593 (100%)	68 (100%)
Yavapai					
<2,500 g	127 (8%)	84 (10%)	0 (0%)	37 (6%)	6 (5%)
2,500+ g	1,537 (92%)	777 (90%)	0 (0%)	635 (94%)	125 (95%)
Total	1,664 (100%)	861 (100%)	0 (0%)	672 (100%)	131 (100%)

Source: Arizona Department of Health Services, Arizona Health Status and Vital Statistics, 1998.
The three comparison counties are *italicized.*

Three of the demonstration and two of the comparison counties had a higher percent of low birth-weight births for AHCCCS mothers than the overall county percentage that included all types of payment. However, private insurance payment for births had fewer low birth-weight births than the county averages in all six counties.

Table 27 provides selected 1997 age-specific chronic disease estimates in the six counties. The estimates provided by the Arizona Department of Health Services, Chronic Disease Epidemiology, were based on the 1997 National Health Interview Survey. These estimates are useful in determining the number of persons who may use disease specific county programs. There are two limitations to the estimates. These are (1) there may be underestimation of the specific disease numbers for minority populations who have high prevalence rates of these diseases, such as diabetes in the American Indian and Hispanic populations, and (2) there may be underestimation of the disease numbers that are affected by environmental factors, such as high air pollution, that may have resulted in higher incidences of pulmonary diseases.

The five-year age-adjusted mortality rates for selected chronic health conditions for each of the six counties and Arizona is summarized in Table 28. When available, these mortality rates were compared to the *Healthy People 2000* objectives (targets). During 1994 through 1998, the Arizona mortality rates for coronary heart disease (117.8 to 100.4), cardiovascular disease (192.4 to 163.7), stroke (30.7 to 28.0), and cancer rates (132.3 to 114.2) decreased, while diabetes increased (19.0 to 21.3). Even though Arizona had made significant progress in lowering the mortality rates for the coronary heart disease, cardiovascular disease, and stroke, they were still higher than the *Healthy People 2000* targets. In 1998, Graham (85.2), La Paz (96.9) and Yavapai (95.8) Counties coronary heart disease mortality rates were lower than the *Healthy People 2000* target of 100.0. Only Cochise County had lower stroke (19.6) and chronic obstructive pulmonary disease mortality rates (21.6) than *Healthy People 2000* targets of 20.0 and 25.0. Pinal (122.0), La Paz (111.6), and Yavapai (117.8) Counties' cancer (all types) mortality rates were lower than the *Healthy People 2000* target of 130.0.

In reviewing the available data, county level data on morbidity rates was quite limited. The only morbidity rates reported were those related to communicable diseases. These morbidity rates were compared to either *Healthy People 2000* or Arizona objectives (targets). Table 29 summarizes the selected age-adjusted morbidity rates for the six counties and Arizona for 1994 through 1998. Chicken pox (168.0 to 35.4), gonorrhea (89.3 to 88.3), Hepatitis A (53.5 to 39.0), and tuberculosis (6.2 to 5.4) had decreased during the five-year period, while syphilis (10.4 to 14.8) and valley fever (14.3 to 30.4) had increased. In 1998, all six counties had gonorrhea, hepatitis, and tuberculosis rates lower than the state rates. However, Pinal County had the highest gonorrhea rate (47.0) and hepatitis A rate (25.5) of the six counties. Pinal County also had the highest syphilis rate (21.6), while the other five counties had rates (2.2 to 6.0) lower than the state rate of 14.8. Of the six counties, La Paz had the highest tuberculosis rate of 5.2. Pinal (51.0) and La Paz (51.8) had higher valley fever rates than the state rate of 30.4

Table 27 Selected Chronic Diseases Estimates Based on National Health Interview Survey for the Six RMCC Counties and Arizona, 1997

County	Population		< 18 Yrs Total #	18-44 Yrs Total #	45-64 Yrs Total #	65-74 Yrs Total #	75 + Yrs Total #
Arizona	4,334,237		1,206,618	1,748,187	822,495	291,193	265,744
Cochise	108,591		30,586	41,385	21,474	8,375	6,771
Graham	30,052		8,650	11,696	5,545	2,206	1,955
Pinal	132,840		37,360	42,006	27,202	11,706	14,566
La Paz	*15,933*		*4,107*	*5,217*	*3,453*	*1,686*	*1,530*
Mohave	*123,741*		*29,172*	*36,904*	*29,865*	*15,951*	*11,849*
Yavapai	*130,626*		*25,941*	*37,712*	*33,338*	*18,488*	*15,147*
Condition County	**Population**	**Total Cases**	**< 18 Yrs. Cond. #**	**18-44 Yrs Cond. #**	**45-64 Yrs Cond. #**	**65-74 Yrs Cond. #**	**75 + Yrs Cond. #**
Arthritis							
Arizona Age %	4,334,237	583,719	2,896 0.5%	94,577 16.2%	213,766 36.6%	129,377 22.2%	143,103 24.5%
Cochise	108,591	15,261	73	2,239	5,581	3,721	3,646
Graham	30,052	4,128	21	633	1,441	980	1,053
Pinal	132,840	22,477	90	2,273	7,070	5,201	7,844
La Paz	*15,993*	*2,763*	*10*	*282*	*897*	*749*	*824*
Mohave	*123,741*	*23,296*	*70*	*1,997*	*7,762*	*7,087*	*6,381*
Yavapai	*130,626*	*27,138*	*62*	*2,040*	*8,665*	*8,214*	*8,157*
Asthma							
Arizona Age %	4,334,237	213,739	76,500 35.8%	78,494 36.7%	37,012 17.3%	12,725 5.9%	9,009 0.4%
Cochise	108,591	5,359	1,939	1,858	966	366	230
Graham	30,052	1,486	548	525	250	96	66
Pinal	132,840	6,484	2,369	1,886	1,224	512	494
La Paz	*15,993*	*776*	*260*	*234*	*155*	*74*	*52*
Mohave	*123,741*	*5,949*	*1,850*	*1,657*	*1,344*	*697*	*402*
Yavapai	*130,626*	*6,160*	*1,645*	*1,693*	*1,500*	*808*	*513*

Source: ADHS, Chronic Disease Epidemiology, April 2, 1997. The three comparison counties are *italicized.*

Table 27 **Selected Chronic Diseases Estimates Based on the National Health Interview Survey for the Six RMCC Counties and Arizona, 1997 (Cont.)**

Condition County	Population	Total Cases	< 18 Yrs. Cond. #	18-44 Yrs Cond. #	45-64 Yrs Cond. #	65-74 Yrs Cond. #	75 + Yrs Cond. #
Bronchitis							
Arizona Age %	4,334,237	232,584	64,675 5.4%	82,165 4.7%	47,951 5.8%	22,859 7.9%	14,935 5.6%
Cochise	108,591	5,874	1,639	1,945	1,252	657	381
Graham	30,052	1,620	464	550	323	173	110
Pinal	132,840	7,300	2,002	1,974	1,586	919	819
La Paz	*15,993*	*885*	*220*	*245*	*201*	*132*	*86*
Mohave	*123,741*	*6,957*	*1,564*	*1,734*	*1,741*	*1,252*	*666*
Yavapai	*130,626*	*7,409*	*1,390*	*1,772*	*1,944*	*1,451*	*851*
CardioVas							
Arizona Age %	4,334,237	58,823	241 .02%	1,923 0.1%	14,229 1.73%	19,044 6.5%	23,385 8.8%
Cochise	108,591	1,567	6	46	372	548	596
Graham	30,052	427	2	13	96	144	172
Pinal	132,840	2,572	7	46	471	766	1,282
La Paz	*15,993*	*311*	*1*	*6*	*60*	*110*	*135*
Mohave	*123,741*	*2,649*	*6*	*41*	*517*	*1,043*	*1,043*
Yavapai	*130,626*	*3,165*	*5*	*41*	*577*	*1,209*	*1,333*
Diabetes							
Arizona Age %	4,334,237	128,882	1,569 0.13%	20,104 1.2%	46,060 5.6%	33,167 11.4%	27,983 10.5%
Cochise	108,591	3,385	40	476	1,203	954	713
Graham	30,052	913	11	135	311	251	206
Pinal	132,840	4,922	49	483	1,523	1,333	1,534
La Paz	*15,993*	*612*	*5*	*60*	*193*	*192*	*161*
Mohave	*123,741*	*5,199*	*38*	*424*	*1,672*	*1,817*	*1,248*
Yavapai	*130,626*	*6,035*	*34*	*434*	*1,867*	*2,106*	*1,595*

Source: ADHS, Chronic Disease Epidemiology, April 2, 1997. The three comparison counties are *italicized.*

Table 27 **Selected Chronic Diseases Estimates Based on the National Health Interview Survey for the Six RMCC Counties and Arizona, 1997 (Cont.)**

Condition County	Population	Total Cases	< 18 Yrs. Cond. #	18-44 Yrs Cond. #	45-64 Yrs Cond. #	65-74 Yrs Cond. #	75 + Yrs Cond. #
Emphysema							
Arizona Age %	4,334,237	34,156	0 0.0%	2,098 .12%	12,337 1.5%	8,852 3.0%	10,869 4.1%
Cochise	108,591	903	0	50	322	255	277
Graham	30,052	244	0	14	83	67	80
Pinal	132,840	1,410	0	50	408	356	596
La Paz	*15,993*	*172*	*0*	*6*	*52*	*51*	*63*
Mohave	*123,741*	*1,462*	*0*	*44*	*448*	*485*	*485*
Yavapai	*130,626*	*1,727*	*0*	*45*	*500*	*562*	*620*
Isch H Dis							
Arizona *Age %*	*4,334,237*	*145,657*	*0* *0.0%*	*8,042* *0.5%*	*50,337* *6.1%*	*38,408* *13.2%*	*48,870* *18.4%*
Cochise	*108,591*	*3,854*	*0*	*190*	*1,314*	*1,105*	*1,245*
Graham	*30,052*	*1,044*	*0*	*54*	*339*	*291*	*360*
Pinal	*132,840*	*6,081*	*0*	*193*	*1,665*	*1,544*	*2,679*
La Paz	*15,993*	*739*	*0*	*24*	*211*	*222*	*281*
Mohave	*123,741*	*6,280*	*0*	*170*	*1,828*	*2,104*	*2,179*
Yavapai	*130,626*	*7,438*	*0*	*173*	*2,040*	*2,439*	*2,786*
Hypertens							
Arizona Age %	4,334,237	481,421	1,327 0.11%	95,101 5.4%	186,213 22.6%	105,237 36.1%	93,542 35.2%
Cochise	108,591	12,557	34	2,251	4,862	3,027	2,383
Graham	30,052	3,387	10	636	1,255	797	688
Pinal	132,840	17,843	41	2,285	6,159	4,231	5,127
La Paz	*15,993*	*2,218*	*5*	*284*	*782*	*609*	*539*
Mohave	*123,741*	*18,737*	*32*	*2,008*	*6,761*	*5,765*	*4,171*
Yavapai	*130,626*	*21,641*	*29*	*2,052*	*7,548*	*6,682*	*5,332*

Source: ADHS, Chronic Disease Epidemiology, April 2, 1997. The three comparison counties are *italicized.*

Table 28 Meeting Selected Healthy People 2000 Age-Adjusted Mortality Rate Objectives for the Six RMCC Counties and Arizona, 1994-98

Health Area Rate County	1994	1995	1996	1997	1998
Coronary Heart Dis.: 100.0					
Arizona	117.8	111.0	103.5	102.2	100.4
Cochise	115.1	121.9	124.1	111.1	114.9
Graham	91.6	91.2	83.7	68.1	85.2
Pinal	110.2	112.2	89.9	111.9	104.0
La Paz	*79.1*	*108.6*	*113.0*	*98.9*	*96.9*
Mohave	*105.2*	*98.9*	*103.2*	*112.1*	*133.8*
Yavapai	*98.6*	*99.2*	*87.6*	*95.5*	*95.8*
Cardiovasc. Dis.: 141.5					
Arizona	192.4	180.2	171.9	166.9	163.7
Cochise	195.3	207.3	186.3	180.1	173.9
Graham	179.3	180.0	188.1	176.4	165.9
Pinal	175.9	182.5	151.7	174.1	174.4
La Paz	*214.3*	*211.0*	*155.8*	*149.0*	*170.2*
Mohave	*191.6*	*169.4*	*168.6*	*176.2*	*208.7*
Yavapai	*153.6*	*165.6*	*149.2*	*152.2*	*164.0*
Stroke: 20					
Arizona	30.7	28.5	29.0	29.2	28.0
Cochise	26.4	36.7	21.5	27.0	19.6
Graham	32.2	36.6	28.3	29.8	27.5
Pinal	34.2	27.5	23.3	28.4	25.5
La Paz	*30.2*	*10.2*	*18.4*	*22.8*	*37.3*
Mohave	*24.7*	*19.9*	*23.3*	*26.1*	*26.4*
Yavapai	*26.1*	*24.8*	*25.6*	*24.0*	*26.8*

Source: Arizona Department of Health Services, Arizona Health Status and Vital Statistics, 1994-1998. Number of death per 100,000 population (age-adjusted).

Table 28 **Meeting Selected Healthy People 2000 Age-Adjusted Mortality Rate Objectives for the Six RMCC Counties and Arizona, 1994-98 (Cont.)**

Health Area Rate County	1994	1995	1996	1997	1998
Chr. Obst. Pulm. Dis: 25.0					
Arizona	27.1	27.2	27.0	28.9	28.0
Cochise	24.4	23.3	31.5	22.5	21.6
Graham	23.2	20.3	32.3	33.1	35.9
Pinal	27.6	31.4	36.3	36.5	32.7
La Paz	*20.4*	*24.6*	*23.6*	*23.4*	*25.3*
Mohave	*29.7*	*37.0*	*31.2*	*34.7*	*37.3*
Yavapai	*29.7*	*28.0*	*24.8*	*23.6*	*27.5*
Diabetes: No 2000 Objec.					
Arizona	19.0	19.4	20.1	20.6	21.3
Cochise	18.2	24.6	19.1	24.0	27.0
Graham	34.9	31.9	44.9	15.5	60.1
Pinal	31.6	23.5	34.7	34.3	37.9
La Paz	*45.8*	*6.1*	*33.0*	*10.7*	*20.7*
Mohave	*25.7*	*26.1*	*26.6*	*30.2*	*25.4*
Yavapai	*19.9*	*24.1*	*25.9*	*30.1*	*18.1*
Cancer (All Types): 130.0					
Arizona	132.3	121.7	119.3	116.5	114.2
Cochise	133.8	122.4	121.9	123.9	136.7
Graham	100.5	134.8	137.2	99.3	131.5
Pinal	131.0	138.4	109.2	120.8	122.0
La Paz	*120.5*	*146.6*	*108.5*	*128.9*	*111.6*
Mohave	*143.1*	*134.9*	*130.6*	*144.3*	*131.7*
Yavapai	*121.5*	*130.6*	*125.5*	*120.3*	*117.8*

Source: Arizona Department of Health Services, Arizona Health Status and Vital Statistics, 1994-1998. Number of death per 100,000 population (age-adjusted).

Table 28 **Meeting Selected Healthy People 2000 Age-Adjusted Mortality Rate Objectives for the Six RMCC Counties and Arizona, 1994-98 (Cont.)**

Health Area Rate County	1994	1995	1996	1997	1998
Lung Cancer: 42.0					
Arizona	33.3	34.1	33.5	32.2	31.8
Cochise	33.4	30.5	39.7	36.2	36.5
Graham	28.5	27.5	32.4	31.4	30.9
Pinal	33.6	43.5	36.4	32.9	36.8
La Paz	*33.0*	*27.2*	*22.4*	*38.7*	*29.1*
Mohave	*51.1*	*48.3*	*47.1*	*46.8*	*46.8*
Yavapai	*39.6*	*36.2*	*38.5*	*30.2*	*33.2*
Breast Cancer: 20.6					
Arizona	21.4	17.2	17.2	19.3	18.2
Cochise	20.1	12.4	28.8	23.4	27.9
Graham	13.2	23.0	35.0	3.2	33.0
Pinal	16.1	26.9	7.4	24.2	20.5
La Paz	*18.9*	*21.9*	*37.0*	*31.2*	*33.9*
Mohave	*17.4*	*12.5*	*15.1*	*23.8*	*16.0*
Yavapai	*25.6*	*24.2*	*12.1*	*25.6*	*19.0*
Colorectal Cancer: 13.2					
Arizona	12.9	11.5	11.7	10.7	11.1
Cochise	10.0	9.4	8.0	12.3	10.1
Graham	7.2	5.5	5.4	8.6	13.7
Pinal	18.3	11.0	10.5	11.4	10.1
La Paz	14.0	18.2	7.3	1.8	15.2
Mohave	12.0	10.3	11.4	11.2	9.4
Yavapai	9.7	13.5	11.9	9.7	9.5

Source: Arizona Department of Health Services, Arizona Health Status and Vital Statistics, 1994-1998. Number of death per 100,000 population (age-adjusted).

Table 29 Selected Age-Adjusted Morbidity Rates for the Six RMCC Counties and Arizona, 1994-98

Health Area Rate: County	1994	1995	1996	1997	1998
Chickenpox: (NDA)					
Arizona	168.0	63.5	74.4	43.2	35.4
Cochise	234.0	116.5	122.7	125.9	113.1
Graham	10.5	95.6	19.3	11.7	12
Pinal	100.0	185.0	99.9	96.9	NDA
La Paz	*13.1*	*0.0*	*0.0*	*0.0*	*NDA*
Mohave	*106.0*	*8.7*	*56.4*	*67.8*	*0.7*
Yavapai	*342.0*	*55.7*	*17.8*	*17.9*	*45.9*
Gonorrhea: 225.0 (AZ Obj.)					
Arizona	89.3	91.8	83.0	82.6	88.3
Cochise	26.0	40.9	19.8	18.0	20.3
Graham	13.8	29.0	21.9	3.1	21.0
Pinal	58.3	48.5	38.6	29.6	47.0
La Paz	*33.3*	*29.4*	*11.8*	*5.3*	*10.4*
Mohave	*15.9*	*19.8*	*8.3*	*17.3*	*11.6*
Yavapai	*9.1*	*14.8*	*7.6*	*6.5*	*7.6*
Syphilis: 10.0 (U.S. Obj.)					
Arizona	10.4	9.9	10.4	13.0	14.8
Cochise	7.7	5.5	4.4	5.1	2.5
Graham	3.5	16.1	3.2	0.0	6.0
Pinal	7.1	5.1	8.3	24.8	21.6
La Paz	*6.7*	*0.0*	*5.6*	*0.0*	*5.2*
Mohave	*2.7*	*0.8*	*1.6*	*0.0*	*2.2*
Yavapai	*0.0*	*2.3*	*1.5*	*1.4*	*2.8*

Source: Arizona Department of Health Services, Arizona Health Status and Vital Statistics, 1994-1998. Number of reported cases per 100,000 population (age-adjusted).
NDA = No Data Available.

Table 29 Trend for Selected Age-Adjusted Morbidity Rates for the Six RMCC Counties, 1994-98 (Cont.)

Health Area Rate County	1994	1995	1996	1997	1998
Hepatitis A: (NDA)					
Arizona	53.5	32.5	39.6	50.7	39.0
Cochise	11.5	7.3	53.1	50.5	16.9
Graham	90.9	15.9	41.7	6.2	6.0
Pinal	52.0	54.3	88.1	79.4	25.5
La Paz	*19.6*	*12.1*	*11.0*	*10.7*	*5.2*
Mohave	*65.5*	*55.4*	*16.4*	*104.0*	*18.2*
Yavapai	*34.0*	*32.2*	*17.0*	*31.5*	*18.8*
Tuberculosis: 3.5 (AZ Obj.)					
Arizona	6.2	7.6	6.3	6.4	5.4
Cochise	2.0	0.9	2.6	5.1	1.7
Graham	3.5	9.6	3.2	9.3	3.0
Pinal	7.9	4.4	13.9	12.1	4.6
La Paz	*0.0*	*6.1*	*5.5*	*5.3*	*5.2*
Mohave	*4.4*	*1.6*	*6.3*	*4.5*	*4.4*
Yavapai	*1.7*	*2.4*	*2.2*	*0.7*	*1.4*
Valley Fever: (NDA)					
Arizona	14.3	14.8	14.7	20.8	30.4
Cochise	4.8	3.6	1.7	2.6	2.5
Graham	7.0	12.7	12.8	6.2	15.0
Pinal	27.6	30.1	38.8	38.3	51.0
La Paz	*6.5*	*0.0*	*27.5*	*26.6*	*51.8*
Mohave	*9.7*	*15.8*	*10.2*	*10.6*	*17.4*
Yavapai	*4.2*	*1.6*	*3.7*	*2.9*	*5.6*

Source: Arizona Department of Health Services, Arizona Health Status and Vital Statistics, 1994-1998. Number of reported cases per 100,000 population (age-adjusted).

Three Demonstration Counties' Activity Summary

During the early years of the Clinton Administration, there was an attempt to reform the U.S. Health Care System to provide universal health care coverage and access to health services for the uninsured population. Managed care was one of the corner stones of the proposed health care reform. Since managed care was created in the urban setting and not in the rural setting, the Agency for Health Care Policy and Research decided to create five Rural Managed Care Centers to determine whether managed care would work in rural areas. The Rural Managed Care Centers facilitated the development and implementation of demonstration projects for the expansion and promotion of managed care that would lead to increased access to primary care and prevention services for rural residents. Of the five RMCC state sites, Arizona had the greatest managed care penetration.

During the five-year project, the demonstration counties had undergone significant health care environmental changes (e.g., health care financing, health care leadership changes, health facility ownership changes, and health facility closures). There had been three major health care financing related changes in the three counties (implementation of Welfare Reform, KidsCare, and Premium Sharing). The decreasing trend in AHCCCS enrollment numbers during 1994 to 1998 in the counties (Cochise: 13.3% to 10.8%, Graham: 15.3% to 12.9%, and Pinal: 15.3% to 10.2%) may have been attributed to the effects of the Welfare Reform impact on Title XIX recipients losing their medical benefits. The decreasing AHCCCS enrollment trend during the previous five-years reversed upward in 1999 for all three counties. This was due to both the statewide and counties' efforts to enroll children into KidsCare (Arizona's CHIP). If a child applied for KidsCare and was eligible for AHCCCS, the child would be enrolled in AHCCCS. During the three-year pilot, a total of 1,290 individuals in Cochise and Pinal Counties were enrolled in Premium Sharing.

Over a five-year period from 1993 to 1997, there was a steady growth of Medicare HMO enrollees in the state of Arizona. In 1998, Medicare HMOs began to withdraw from the rural counties. Of the three demonstration counties, Graham had been impacted the most -- in 1996, it had a high of 37 percent Medicare HMO enrollment and dropped to a low of 1 percent in 1999. Pinal remained as one of the highest Medicare HMO penetrated rural counties in the state (44% in 1999). However, this may change, as two of the largest Medicare HMOs in the state will be withdrawing from parts of Pinal County at the end of the year 2000.

In addition to the counties' health care financing changes, there were several major health care leadership changes in two of the three counties. Graham County did not have any major health care leadership changes. Cochise County had undergone Chief Executive Officer (CEO) changes in three of the five community hospitals (Copper Queen Community Hospital in Bisbee, Sierra Vista Community Hospital, and Southeast Arizona Medical Center in Douglas, with two changes). Pinal County had two CEO changes in the Casa Grande Regional Medical Center, the county's largest hospital. In addition, the two major

physician alliances in Cochise County, Arizona Family Care Associates (AFCA) and Cochise Health Alliance (CHA), had undergone changes in their Executive Director positions. There was also a change of Director in the Pinal County Health Department.

There have been several changes in Pinal County's health care delivery systems. In Sacaton, the Hu-Hu-Kam Hospital was taken over by the Gila River Indian Tribe from the Indian Health Service. The Tribe also formed its own Gila River Tribal Health Corporation. In January 1998, the Oracle Clinic, a health provider for several managed care plans, located in the eastern part of the county, closed its doors, but reopened again through community action and assistance from the RMCC staff. The reprieve was brief, however, and it closed again in August 2000. Regional Health Systems, one of earliest rural Provider Health Organizations (PHO) in the state and the county's largest managed care plan, filed for reorganization in early 1997. Quorum, an out-of-state for-profit hospital management firm, took over the Casa Grande Regional Medical Center and Central Arizona Medical Center in Florence, both part of the Regional Health Systems. The oldest community hospital in Arizona, Central Arizona Medical Center, closed its doors on October 1, 1999. It appears that the Casa Grande Regional Medical Center has rebounded from its previous financial troubles.

In 1999, Tucson Medical Center, a major urban hospital, withdrew its financial support of the San Manuel Health Center, located in the eastern part of Pinal County. If the clinic closed, there would have been several managed care plans without a local health care provider. The RMCC staff, working with the community and other interested parties including the governor's office, found a new owner for the clinic, the Sun Life Community Health Center.

Graham County had not undergone any major changes in its health care system, but Cochise County did have some. In Cochise, Raymond W. Bliss Army Community Hospital at Fort Huachuca had closed its inpatient services and maintained some limited outpatient services. The Southeast Arizona Medical Center in Douglas is struggling to keep its doors open and is seeking new ownership. Elfrida is the home of the new Chiricahua Community Health Center.

From the outset of the project, the RMCC staff have been sensitive to the often-expressed rural concern that urban outsiders were usurping local rural autonomy. RMCC advisory committees were established in each of the three demonstration counties. The RMCC worked in partnership with the counties to develop and use innovation in the organization, financing, and delivery of health services to the targeted underserved rural populations, leading to the expansion and promotion of managed care networks, including non-managed health care delivery systems. The Center used a variety of strategies to identify, design, and implement its demonstration activities and developed collaborative approaches, some ongoing, others ad hoc, that matched the diversity of health care systems presented in the three demonstration counties. The RMCC also provided technical assistance to the demonstration counties to facilitate the planning and

implementation of the demonstration projects. The technical assistance included, but was not limited to, providing county data for health systems analysis and/or county health assessment, performing the role of liaison between the demonstration counties and state agencies (e.g., AHCCCS and ADHS), conducting training workshops on the AHCCCS, Premium Sharing, and Kidscare programs, facilitating meetings, and providing requested expertise.

Table 30 provides a summary of some of the county demonstration projects. In Cochise, there were four major demonstration activities. The Baby Arizona Program promotes early access to prenatal care and streamlines eligibility for AHCCCS coverage for pregnant women. In 1997, Cochise County was one of the rural counties with the lowest AHCCCS enrollment through Baby Arizona. The Cochise County Coalition for Primary and Preventive Health Care determined that there was a need in the county to increase the number of pregnant women enrolled in the AHCCCS Baby Arizona Program. The RMCC staff provided the facilitation of the Baby Arizona planning meetings, assisted in the mobilization of the county to establish the infrastructure to support pregnant women seeking care through Baby Arizona, and performed the role of the liaison between the county and the Baby Arizona Program in Phoenix. The promotion of Baby Arizona in the county included both managed care and non-managed health care delivery systems (e.g., the five community hospitals, two major physician alliances, community health center, county health department, and two AHCCCS managed care plans). As the result of the Baby Arizona one-year promotion, there was an increase of 6 percent of pregnant women receiving prenatal care in the first trimester.

One of the access to health care concerns in the county was the number of uninsured. The second demonstration activity was to decrease the number of uninsured in the county by enrolling the uninsured into the Premium Sharing, KidsCare, and AHCCCS programs. Prior to the selection of the two rural counties, the RMCC staff had provided baseline data for Cochise and Pinal Counties to the Legislative Committee whose charge was to recommend the rural counties to the Arizona Legislature for final approval. The RMCC staff provided updates on the implementation status of the Premium Sharing Program, worked with the Coalition in developing strategies to enroll the uninsured into the programs, arranged for the Premium Sharing, AHCCCS, and KidsCare training workshops, and performed the role of the liaison between the county and AHCCCS who administered all three programs. In July 2000, the Premium Sharing Program enrollment for Cochise County was 11.9 percent, which exceeded the target enrollment for the county of 4.7 percent.

The third activity was to begin the process of exploring the possibility of developing a U.S.-Mexico cross-border health provider network. There was interest by the Cochise County Department of Health and Social Services and Copper Queen Community Hospital in Bisbee to develop a closer relationship with the physicians and clinics in Naco, Sonora, Mexico. A partnership was formed that included the RMCC, county health department, and

Table 30 Selected RMCC County Demonstration Activity Summary

Cochise County • AHCCCS Baby Arizona Expansion • Public Supported Health Insurance Expansion • Cross-Border Health Provider Network Expansion (U.S.-Mexico)
Graham County • County Assessment of Health Problems • Medicare HMOs Pullout Replacement • Cross-Border Health Provider Network Expansion (Tribal)
Pinal County • County Wide Health System Analysis • Public Supported Health Insurance Expansion • Cross-Border Health Provider Network Expansion (Tribal)

hospital. There were two major cross-border relationship building events. The first was a one-day visit by binational health care providers to health care facilities in Bisbee, Arizona (health department and hospital) and Naco, Sonora (two health clinics) followed by a get-to-know-you dinner meeting. The second event was a binational continuing education program that included presentations on "Diabetes and Cardiovascular Disease" given in English by a U.S.-trained physician and "Depression" given in Spanish by a Mexico-trained physician. Each of these presentations was followed by a dialogue session to gain insight into each country's medical practice in these two areas. The participants provided very positive feedback on both events.

The fourth activity was to determine the feasibility of developing a health service district to support primary health care services in Tombstone. The feasibility study was conducted by an independent consulting firm contracted by the RMCC. The study identified that providing these services would require a base level of support through some combination of health services district taxes, grant funding to provide service to uninsured residents and /or other grant sources. The study also determined that there was not enough community support for the formation of the health services district.

There were three major demonstration activities in Graham County. The Healthy Community Coalition requested that the RMCC provide technical assistance in conducting a county-wide health assessment. The RMCC staff provided the county data for the assessment. To expand cross-border health provider linkage, the RMCC staff invited health care providers from the San Carlos Indian Reservation to participate in the county health assessment discussion, since the reservation covers one-third of Graham. When Intergroup of Arizona Senior and Health Partners Health Plan Senior pulled out of Graham County, the RMCC staff assisted the county by facilitating discussions with Premier Healthcare of Arizona to replace two Medicare HMOs. As the result of the pullouts, the

Medicare HMO enrollment for March 1998 had dropped to 94 seniors, but returned to 1,221 when Premier Healthcare replaced the two plans in December 1998.

In Pinal County, there were three major demonstration activities. The Pinal County Collaborative Health Care Network was very concerned with the declining enrollment trends in the AHCCCS program. The Network requested that the RMCC conduct a county-wide health systems analysis to identify where the primary care and preventive services gaps are located in the county. The RMCC staff provided the county data and expertise to conduct the health systems analysis. The analysis included commercial and AHCCCS managed care plans, non-managed health care delivery systems (e.g., community health center and health department), county Medicaid behavioral health system, and Gila River Tribal Health Corporation. The analysis results were used by each participant to plan its next year health programs. This analysis provided an excellent opportunity for the Gila River Tribal Health Corporation to strengthen its linkages with the various health care delivery systems in Pinal County.

The third demonstration activity was to decrease the number of uninsured in the county by encouraging the uninsured to enroll in the Premium Sharing, KidsCare, and AHCCCS programs. The RMCC staff provided updates on the implementation status of the Premium Sharing and KidsCare Programs, worked with the Network in developing strategies to reduce the uninsured, arranged for the Premium Sharing, AHCCCS, and KidsCare training workshops, and performed the role of the liaison between the county and AHCCCS who administered all three programs. The Pinal County enrollment for the Premium Sharing in July 2000 was 7.4 percent, which exceeded the target enrollment for the county of 5.1 percent.

The demonstration counties made greater improvement in providing access to primary health care for their residents than the comparison counties during the five-year period. In 1994, there were nine top 30 medically underserved Primary Care Areas in the demonstration counties (Pinal - 4, Cochise - 3, and Graham - 2) and six in the comparison counties (La Paz - 2, Mohave - 2, and Yavapai - 2). The number of top 30 medically underserved Primary Care Areas decreased by three in the demonstration counties (Pinal - 3, Cochise - 3, and Graham - 0), but increased by four in the comparison counties (La Paz - 3, Mohave - 4, and Yavapai - 3) in 2000. There were five top 10 medically underserved Primary Care Areas in 1994 (demonstration counties - 2 and comparison counties - 3). In 2000, this number in the top 10 increased to seven (demonstration counties - 1 and comparison counties - 6). Appendix B lists the ranking of the top 30 medically underserved PCAs for 1994 and 2000.

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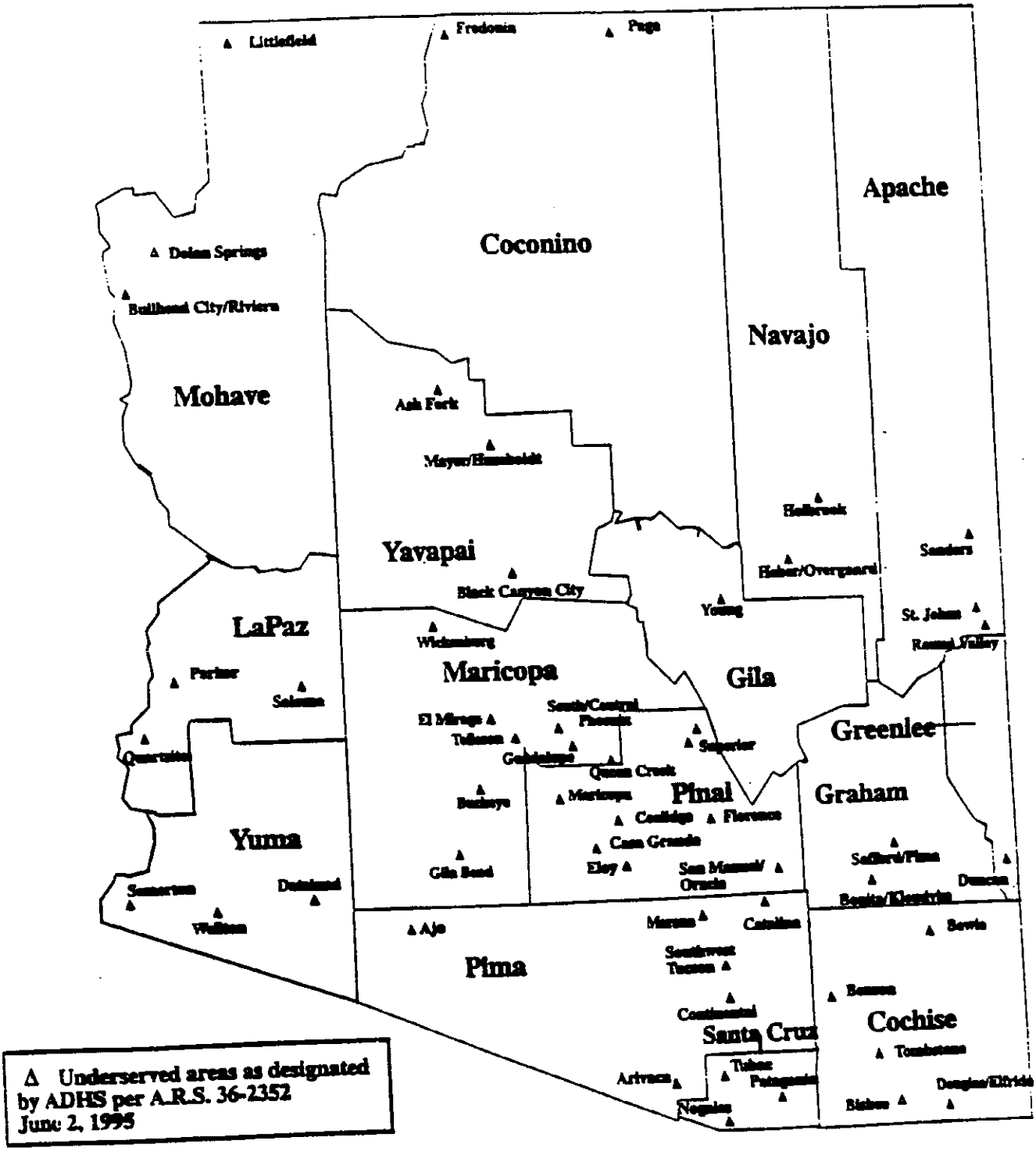
APPENDIX A

ARIZONA MEDICALLY UNDERSERVED AREAS
1995



Δ Underserved areas as designated by ADHS per A.R.S. 36-2352
June 2, 1995

Arizona Department of Health Services

Bureau of Health Systems Development

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JANE DEE HULL, GOVERNOR
CATHERINE R. EDEN, DIRECTOR

2000

DATA DOCUMENTATION:

SOURCES AND SPECIAL EXPLANATIONS
(To accompany Primary Care Area (PCA) Statistical Profile)

DESCRIPTION OF AREA

Primary Care Area (PCA):
A geographic area in which most residents seek primary health services from the same place(s). The PCA is meant to depict the "primary care service seeking patterns" of the residents.*

*** PCA Number:**
A unique 5 digit number has been assigned to each PCA. The first two digits express the Federal Identification (FIPS) code for the county. The third digit indicates the Health Planning Region. The last two digits identify the PCA.

Major Population Center:
Name of PCA. Usually the same as the major population center.

Other Places:
Names of other places included in PCA.

Health Planning Region:
Four multi-county areas have been designated for health planning purposes.

Region 1: Gila, Maricopa, and Pinal
Region 2: Cochise, Graham, Greenlee, Pima, and Santa Cruz
Region 3: Apache, Coconino, Navajo, and Yavapai
Region 5: La Paz, Mohave, and Yuma

Special Tax District:
Category of District: A = Hospital, B = Health, C = Ambulance

State Medically Underserved Area (AZMUA):
Annual designation by Arizona State Government as Underserved Area per A.R.S.§36-2352. (See attached Primary Care Index for indicators and other details.)

Health Personnel Shortage Area (HPSA):
Designation by the United States government as an area with a shortage of health professional personnel.

Codes:

A - Area
P - Population Group
Low-inc. - Low-income
MFW - Migrant Farm Worker
Med. Indig. - Medically Indigent
CO - County

Federal Medically Underserved Area (FedMUA):
Designation by the United States government as an underserved area. A score of 62.0 or below is considered underserved.

Next Nearest Provider:
Location of next nearest primary care service provider.

Second Nearest Provider:
Location of second nearest primary care service provider.

Travel Time, Next:
Travel time by passenger vehicle by most direct route, under normal road and climatic conditions, to provider location.

CODE	TRAVEL TIME	DISTANCE
A	Less than or equal to 20 minutes	Less than or equal to 15 miles
B	21-30 minutes	16-25 miles
C	31-40 minutes	26-35 miles
D	41-60 minutes	36-45 miles
E	61-80 minutes	46-55 miles
F	more than 80 minutes	more than 55 miles

Travel Time, Second:
Same as above but for location of second nearest provider.

DEMOGRAPHICS

POPULATION

Population:
Number of residents estimated, as of July 1, 1999. Based on DES report, "Population Estimates of Arizona Counties and Incorporated Places" and the 1990 Census. Source: Population & Statistics Unit, DES.

Persons Per Square Mile:
Number of residents per square mile of land area, as of July 1, 1999. Based on DES report, "Population Estimates of Arizona Counties and Incorporated Places" and the 1990 Census. Source: Population & Statistics Unit, DES.

By Age:
Number of residents estimated by age groupings, as of July 1, 1999. Based on DES report, "Population Estimates of Arizona Counties and Incorporated Places" and the 1990 Census. Source: Population & Statistics

Ethnicity/Race:
Percent of total population represented by major ethnic/racial groups, per 1990 Census, annualized to current year.

Gender:
Percent of population male or female, per 1990 Census.

Single Parent Families:
Percent of total families that are single parent families, per 1990 Census.

Female Headed Households:
Percent of total households headed by a female, per 1990 Census.

INCOME

Population Below 100% of Poverty:
Percent of total population below 100% of poverty as reported in 1990 Census. (Poverty count was actually done in 1989.)

Population Below 200% of Poverty:
Percent of total population below 200% of poverty as reported in 1990 Census. (Poverty count was actually done in 1989.)

Median Household Income:
Median household income as reported in the 1990 Census.

Children <12 in Poverty Families:
Percent of children less than 12 years old living in families below 100% of Poverty, per 1990 Census.

EDUCATION

Less Than 9th Grade Education:
Percent of population 25 years of age or older with less than a 9th grade education, per 1990 Census.

9th-12th Grade, No Diploma:
Percent of population 25 years of age or older with 9th-12th grade education, no diploma, per 1990 Census.

High School Graduates:
Percent of population 25 years of age or older graduated from high school, per 1990 Census.

Some College:
Percent of population 25 years of age or older with some college, per 1990 Census.

College Degree Holders:
Percent of population 25 years of age or older with a college degree, per 1990 Census.

NON-RESIDENTS

(Year-long, permanent resident equivalent of categories of transient populations. Conversion of numbers of transient population to permanent equivalent is based on methodology from U.S. Federal Register/Vol. 45, No. 223/11-17-80/Page 76001.)

Migrant Agricultural Workers:

Source: "In-Season Farm Labor Report," Arizona Department of Economic Security, Feb. 1992 through June 1993.

Part-time Residents: Available only for entire state.

Tourists:

U.S./Mexico Border Crossings into U.S. vehicle passengers and pedestrians, October, 1992 to September, 1993. Source: U.S. Customs Service, Nogales, Arizona. Estimates by Chambers of Commerce, Cities and Councils of Government. Visitors to National Parks and Recreation Areas. Source: U.S. National Park Service.

Winter Residents:

Source: "AZ Business," Center for Business Research, Arizona State University, August, 1997. Based on survey of mobile home and RV/travel trailer parks. No estimates are available for the number staying in other type of accommodations. Does not include Apache, Greenlee and Navajo counties nor the areas of the city of Prescott and northern Mohave County.

MISCELLANEOUS

Unemployed:

Average percent of unemployment. Source: "Special Unemployment Report for January through December, 1999, for Arizona Local Area Statistics," Arizona Department of Economic Security, Research Administration.

"Uninsured" Births:

Percent of births reporting payee as "self" and/or "unknown," 1994-1998. Source: Division of Public Health Services, Office of Vital Statistics, ADHS.

AHCCCS Enrolled:

Percent of total population enrolled in AHCCCS Program. Source: Report AHAHR431, "Arizona Health Care Cost Containment System AHCCCS Members County by Zip Code Eligibility/Enrollment as of: 01/01/99."

Medicare Beneficiaries:

Percent of total population on Medicare, of enrolled persons age 65 and over. Source: "Table AE11 For Persons Enrolled as of 07/01/98 For Hospital and/or Medical Insurance By Age, Race and Sex, State of Residence and Zipcode for all Persons," Health Care Financing Administration, U.S. Department of Health and Human Services.

Transportation Score:

Adequacy of transportation is determined by the transportation score, which is part of the attached Primary Care Index. The higher the score the less adequate or greater the need for transportation.

RESOURCES

FACILITIES

General Hospitals:
"Yes," means that there is a short-stay, acute care, non-federal general hospital within a driving time of 35 minutes or less. "No," means there is no facility within the driving time. For County, Region and State, number of short stay, acute care, non-federal, non-Indian, general hospitals. Source: Division of Assurance & Licensure Services, ADHS, October, 1999.

Hospital Beds/1000 Residents:
Number of general hospital beds per 1,000 residents. Source: Division of Assurance & Licensure Services, ADHS, October, 1999.

Hospital Designated as Sole Community Provider:
Hospital sole provider of inpatient services in PCA.

Total Specialty Beds:
Number of specialty hospital beds. Source: Division of Assurance & Licensure Services, ADHS, October, 1999.

Skilled Nursing Facilities (Nursing Homes):
Number of nursing homes. Source: Division of Assurance & Licensure Services, ADHS, October, 1999.

Total Nursing Home Beds:
Number of nursing home beds including Hospital-based Skilled Nursing Facility beds. Source: Division of Assurance & Licensure Services, ADHS, October, 1999.

SERVICES

Licensed Home Health Agencies:
Number of home health agencies. Source: Division of Assurance & Licensure Services, ADHS, October, 1999.

Ambulatory Care Sites Type:

A. Comprehensive Health Centers (CHCs): primary health care programs characterized by comprehensive program development on a relatively large scale, together with substantial community involvement. Examples include federally supported community/migrant health centers.

B. Primary Care Centers (PCCs): smaller primary health care programs stimulated and/or subsidized by community initiative, with or without financial assistance from outside the community.

C. Organized Group Practices (OGPs): primary health care programs which consist of at least two full-time physicians in group practice operating autonomously, through a pooled income arrangement, not providing any outreach services.

D. Institutional Extension Practices (IEPs): primary health care programs developed by existing institutions such as hospitals, health departments, American Indian Nation, group practices, etc. Includes rural satellites developed by health departments, established group practices and university medical centers.

E. Other Forms of Practice

Licensed Pharmacies:
Number of licensed pharmacies. Source: Arizona State Board of Pharmacy, December, 1999.

Certified Ambulance Services:
Number of state certified air and ground ambulances. Source: Bureau of Emergency Medical Services, January, 2000.

PERSONNEL

Primary Care Providers:
Number of active providers, and ratio to population of Family Practice, General Practice, Gynecology, Internal Medicine, Obstetrics and Gynecology, Obstetrics, Pediatrics (MD's and DO's) physicians, Nurse Practitioners (NP's) and Physician Assistants (PA's) working in Primary Care. (Includes Federal Doctors) Source: MD's and PA's from the Board of Medical Examiners, February, 2000, and DO's from the Board of Osteopathic Examiners, November, 1999.

Nurse Practitioners:
Nurse Practitioners with active licenses. Source: Arizona State Board of Nursing, November, 1999.

Physician Assistants:
Number of Physician Assistants. Source: Joint Board on the Regulation of Physician Assistants, February, 2000.

Registered Nurses:
Registered Nurses with active licenses. Source: Arizona State Board of Nursing, November, 1999.

Midwives:
Number of certified Midwives. Source: Arizona State Board of Nursing, November, 1999. Number of licensed Midwives. Source: Health and Child Care Review Services, ADHS, September, 1999.

Dentists:
Number of Dentists. Source: Arizona State Board of Dental Examiners, October, 1999.

Emergency Medical:
Number of active emergency medical personnel. Source: Office of Emergency Medical Services, ADHS, November, 1999.

UTILIZATION

AMBULATORY CARE SENSITIVE CONDITIONS

Ambulatory Care Sensitive Conditions:
Those conditions that if properly addressed would not result in a hospitalization. Defined in the Ambulatory Care Access Project of the United Hospital Fund of New York, July 30, 1991. Source: Hospital Discharge Data from the Bureau of Public Health Statistics, Hospital Discharge Registery, ADHS, full year 1998.

Rate of Admissions:
Ambulatory Sensitive Conditions per 1000 residents age less than 65, 1998. Source: ADHS, "Hospital Discharge Data," Bureau of Public Health Statistics, Hospital Discharge Registery.

Points Above/Below Statewide Average:
Ambulatory Sensitive Condition admission points above/below the statewide average, 1998. Source: ADHS, "Hospital Discharge Data," Bureau of Public Health Statistics, Hospital Discharge Registery.

HOSPITALIZATION

Inpatient Days Per 1,000 Residents:
Inpatient days per 1, 000 residents, 1998. Source: ADHS, "Hospital Discharge Data," Bureau of Public Health Statistics, Hospital Discharge Registery.

Inpatient Days Per 1,000 Residents, by Age Group:
Inpatient days per 1, 000 residents by age group, 1998. Source: ADHS, "Hospital Discharge Data," Bureau of Public Health Statistics, Hospital Discharge Registery.

Leading Diagnosis:
Leading diagnosis, 1998. Source: ADHS, "Hospital Discharge Data," Bureau of Public Health Statistics, Hospital Discharge Registery.

Leading Procedure:
Leading procedure, 1998. Source: ADHS, "Hospital Discharge Data," Bureau of Public Health Statistics, Hospital Discharge Registery.

HEALTH STATUS

PLEASE NOTE: **Data in this section if less than 30 counts/events are coded "++," Insufficient Data.**

MORTALITY

Infant Mortality:
Number of infant deaths, less than 1 year old, per 1,000 live births, average over 1994-1998. Source: Division of Public Health Services, Office of Vital Statistics, ADHS.

LEADING CAUSE OF DEATH

Mortality, Leading Cause of Death:
1994-1998. Source: Division of Public Health Services; Office of Vital Statistics, ADHS.

Infant:	Infants less than 1 year old.
Child:	Children 1-14 years of age.
Adolescent:	Adolescents 15-19 years of age.
Young adult:	Young adults 22-44 years of age.
Mid age:	Adults 45-64 years of age.
Elderly:	Elderly 65-84 years of age.
Aged:	Aged older than 85 years of age.

Premature Mortality:
Percent of Arizona deaths below the U.S. Birth Life Expectancy for each year average over 1994-1998. Source of Birth Life Expectancy for each year obtained from HEALTH, UNITED STATES, 1996-97, p. 108. The average Life Expectancy at birth for all races, both sexes in the United States for the years 1994-1998 was 75.75 years.

NATALITY

Fertility Rate:
Number of live births per estimated 1,000 women of childbearing age (15-44 yrs), average for 1994-1998. Source: Division of Public Health Services, Office of Vital Statistics, ADHS. Estimated female population based on DES report, "Population Estimates of Arizona Counties and Incorporated Places" and the 1990 Census using Population Estimation Methodology of the Bureau of Health Systems Development.

Birth Rate:

Live births per 1,000 population, average for 1994-1998. Source: Division of Public Health Services, Office of Vital Statistics, ADHS.

Prenatal Care Visits:

Birth Mothers with 0-4 Prenatal Care Visits per 1,000 live births, average for 1994-1998. Source: Division of Public Health Services, Office of Vital Statistics, ADHS.

Prenatal Care Began:

Percent of birth mothers beginning prenatal care by trimester, average for 1994-1998. Source: Division of Public Health Services, Office of Vital Statistics, ADHS.

Low-Weight Births:

Number of live births weighing 2500 grams (5 lbs, 8 oz.) or less, per 1,000 live births, average for 1994-1998. Source: Division of Public Health Services, Office of Vital Statistics, ADHS.

Teen Births:

Live births per 1,000 women aged 14-19, average for 1994-1998. Source: Division of Public Health Services, Office of Vital Statistics, ADHS.

Appendix B
Top 30 Medically Underserved Primary Care Areas for 1994 and 2000

Rank	PCA 1994	County	PCA 2000	County
1.	Gila Bend	Maricopa	***Salome***	***La Paz***
2.	Dateland	Yuma	***Dolan Springs***	***Mohave***
3.	***Dolan Spring***	***Mohave***	Sanders	Apache
4.	***Littlefield***	***Mohave***	***Ash Fork***	***Yavapai***
5.	**Superior**	**Pinal**	Dateland	Yuma
6.	Sanders	Apache	***Cordes Junction***	***Yavapai***
7.	Wickenburg	Maricopa	***Quartsite***	***La Paz***
8.	**Maricopa**	**Pinal**	***Needles/Topock***	***Mohave***
9.	***Salome***	***La Paz***	***Maricopa***	***Pinal***
10.	Arivaca	Pima	San Luis	Yuma
11.	**Eloy**	**Pinal**	Ajo	Pima
12.	Wellton	Yuma	Gila-Southern	Gila
13.	***Quartzsite***	***La Paz***	Phoenix-South	Maricopa
14.	Ajo	Pima	***Eloy***	***Pinal***
15.	Continental	Pima	***Littlefield***	***Mohave***
16.	Southwest Tucson	Pima	Gila Bend	Maricopa
17.	***Ash Fork***	***Yavapai***	**Coolidge**	**Pinal**
18.	Somerton	Yuma	**Douglas**	**Cochise**
19.	Buckeye	Maricopa	Guadalupe	Maricopa
20.	Guadalupe	Maricopa	Somerton	Yuma
21.	Duncan	Greenlee	***Parker***	***La Paz***
22.	**Fort Grant**	**Graham**	Wickenberg	Maricopa
23.	**Benson**	**Cochise**	***Kingman***	***Mohave***
24.	**Coolidge**	**Pinal**	Tucson-Central	Pima
25.	***Black Canyon***	***Yavapai***	Marana	Pima
26.	**Douglas**	**Cochise**	Nogales	Santa Cruz
27.	**Safford**	**Graham**	St. John	Apache
28.	El Mirage	Maricopa	**Tombstone**	**Cochise**
29.	Marana	Pima	**Elfrida**	**Cochise**
30.	**Willcox**	**Cochise**	***Yavapai-South***	***Yavapai***

Statewide Health Care Insurance Plan Task Force Meeting
November 20, 2000

Impact of Medicare HMO Pullout in Arizona Rural Counties

Howard J. Eng, MS, DrPH

Agency for Health Care Policy and Research
Arizona Rural Managed Care Center
Rural Health Office
University of Arizona
Tucson, Arizona

Five AHCPR Rural Managed Care Centers

• Arizona	University of Arizona Rural Health Office
• Maine	University of Southern Maine Muskie Institute Research Program
• Nebraska	University of Nebraska Medical Center
• Oklahoma	University of Oklahoma Health Sciences Center
• West Virginia	West Virginia University Robert C. Byrd Health Sciences Center

AHCPR Health Policy Issue

Does Managed Care Work in Rural America?

Arizona Rural Managed Care Project Activities

- Develop and Strengthen Managed Care and Health Care Provider Networks
  - Improve Baseline Health Information
  - Expand Provider Partnerships
- Develop Integrated Systems of Care Using Innovations in Financing and Enrollment
  - Coordinate Health Care Delivery
  - Expanding Funding Options
- Integrate Health Systems Across Borders
  - Tribal Nations
  - Arizona Border with Mexico

Arizona Managed Care Profile: 1998

- Arizona in Top Ten HMO Penetration Rates
  - Arizona penetration rate - 47.8%
  - U.S. penetration rate average - 38.8%
- Arizona Is Second in Medicaid Managed Care Penetration
  - Arizona - 85.1% of all Medicaid enrollees
  - Arizona rural counties have 2 Medicaid managed care plans
  - In May 1997, more than half of the U.S. rural counties have some type of Medicaid managed care program
- Arizona Is Second in Medicare HMO Penetration
  - Arizona - 41.8% of the Medicare beneficiary pop.

National Medicare HMO Pullout: 1998-99

- In 1998, estimated 400,000 Seniors (nationwide)
  - HMOs terminated 43 of 347 Medicare risk contracts and another 54 contracts reduced their service areas
  - 28 percent of Medicare risk HMO contracts were not renewed or had service area reductions in 396 counties
- In 1999, estimated 327,000 Seniors (nationwide)
  - HMOs terminated 41 Medicare risk contracts and another 58 contracts reduced their service areas

Arizona Medicare HMO Profile: 1999-2000

- In 1999, there were 10 Medicare HMOs in Arizona
  - Five had pulled out or withdrawn from selected areas
  - Blue Cross Blue Shield of Arizona, Health Plan of Nevada, and Premier Healthcare of Arizona pullout of Arizona
  - Human Health Plan and United Healthcare of Arizona withdrew from parts of Pinal County
- In 2000, there are 7 Medicare HMOs in Arizona
  - Intergroup of Arizona will terminate coverage in Cochise County and southern Pinal County
  - PacificCare of Arizona terminate coverage in southern Pinal County

Six County Medicare HMO Enrollment Penetration for 1994-1999

Year	Cochise	Graham	Pinal	La Paz	Mohave	Yavapai
1994	11%	15%	27%	NA	3%	2%
1995	22%	29%	34%	3%	11%	1%
1996	29%	37%	39%	5%	18%	4%
1997	38%	28%	44%	16%	30%	12%
1998	30%	29%	46%	12%	34%	11%
1999	28%	1%	44%	1%	2%	1%

AAPCC Health Policy Questions

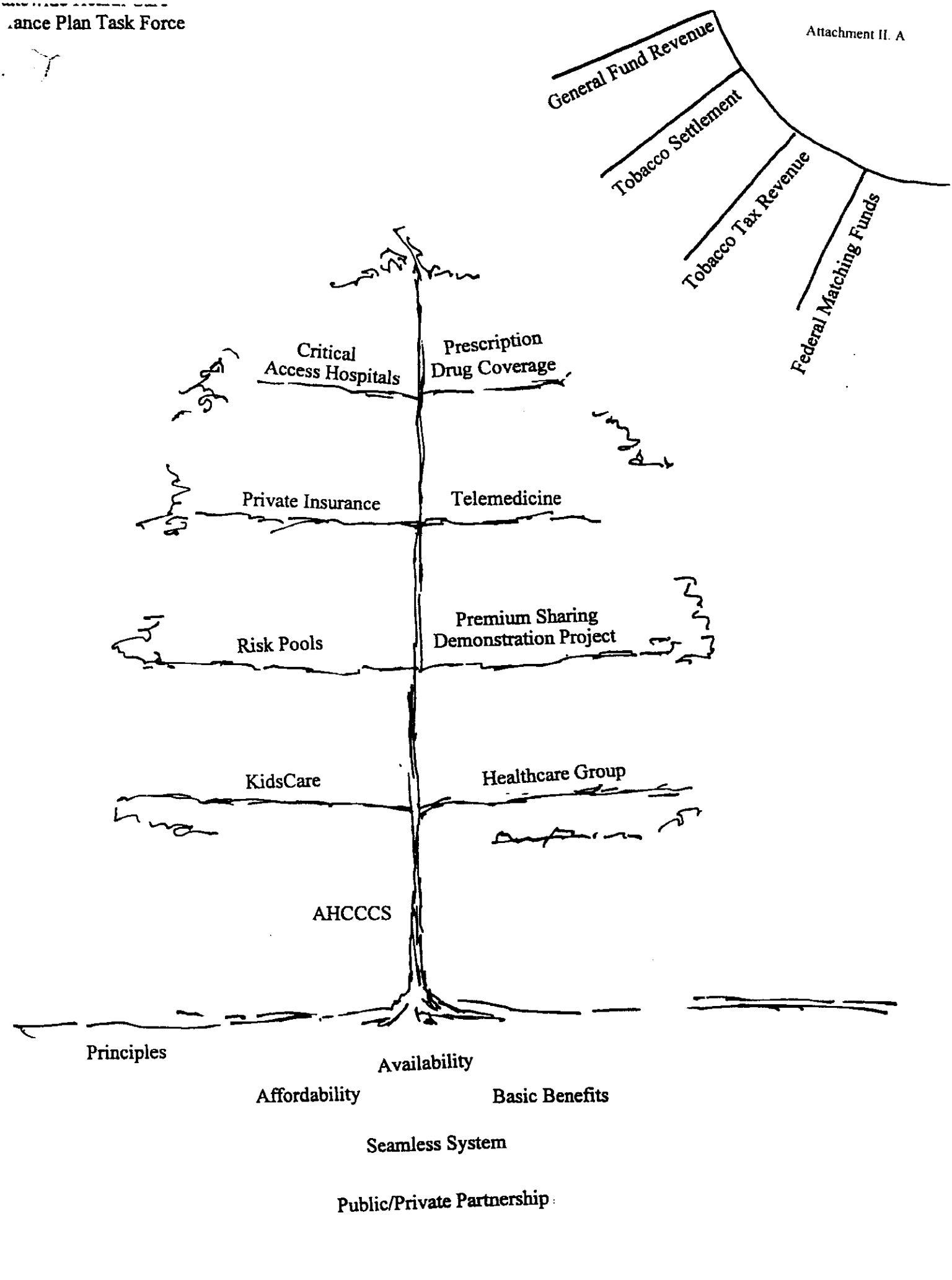
- Are rural AAPCC rates (1/3 to 1/2 less than urban rates) inadequate to sustain managed care companies through the rough start-up period in a new rural market?
- Are the current AAPCC rates high enough to keep managed care companies in rural market?

Six County AAPCC for 1995-1999

Year	Cochise	Graham	Pinal	La Paz	Mohave	Yavapai
1995	$384.55	$348.82	$491.83	$444.46	$447.82	$325.30
1996	398.93	370.97	519.91	459.40	474.48	333.95
1997	398.93	370.97	519.91	459.40	474.48	333.95
1998	406.91	378.39	530.31	468.59	483.97	367.00
1999	445.77	424.25	551.74	505.13	522.27	401.61

Study of Medicare HMO Pullouts: What Happens to 1,830 Disenrolled Seniors?

- Two-third subsequently enrolled in another Medicare HMO
- One-third experienced a decline in benefits
- 39 percent reported higher monthly premium
- One in seven lost prescription drug coverage
- One in five had to switch to a new primary care doctor or specialist

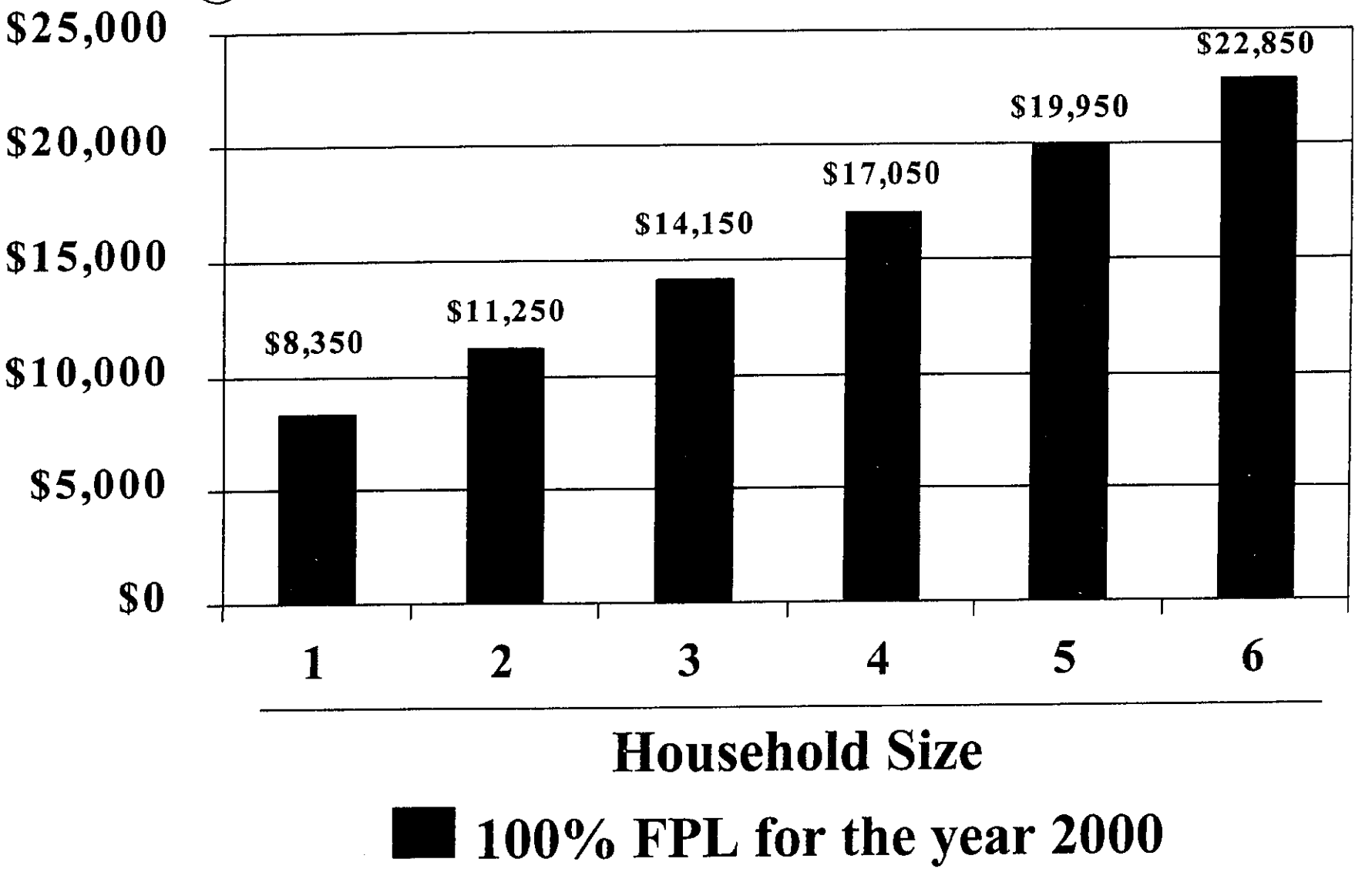

General Fund Revenue
Tobacco Settlement
Tobacco Tax Revenue
Federal Matching Funds
Critical Access Hospitals
Prescription Drug Coverage
Private Insurance
Telemedicine
Risk Pools
Premium Sharing Demonstration Project
KidsCare
Healthcare Group
AHCCCS
Principles
Availability
Affordability
Basic Benefits
Seamless System
Public/Private Partnership

Proposition 204

Expanding Health Care Coverage

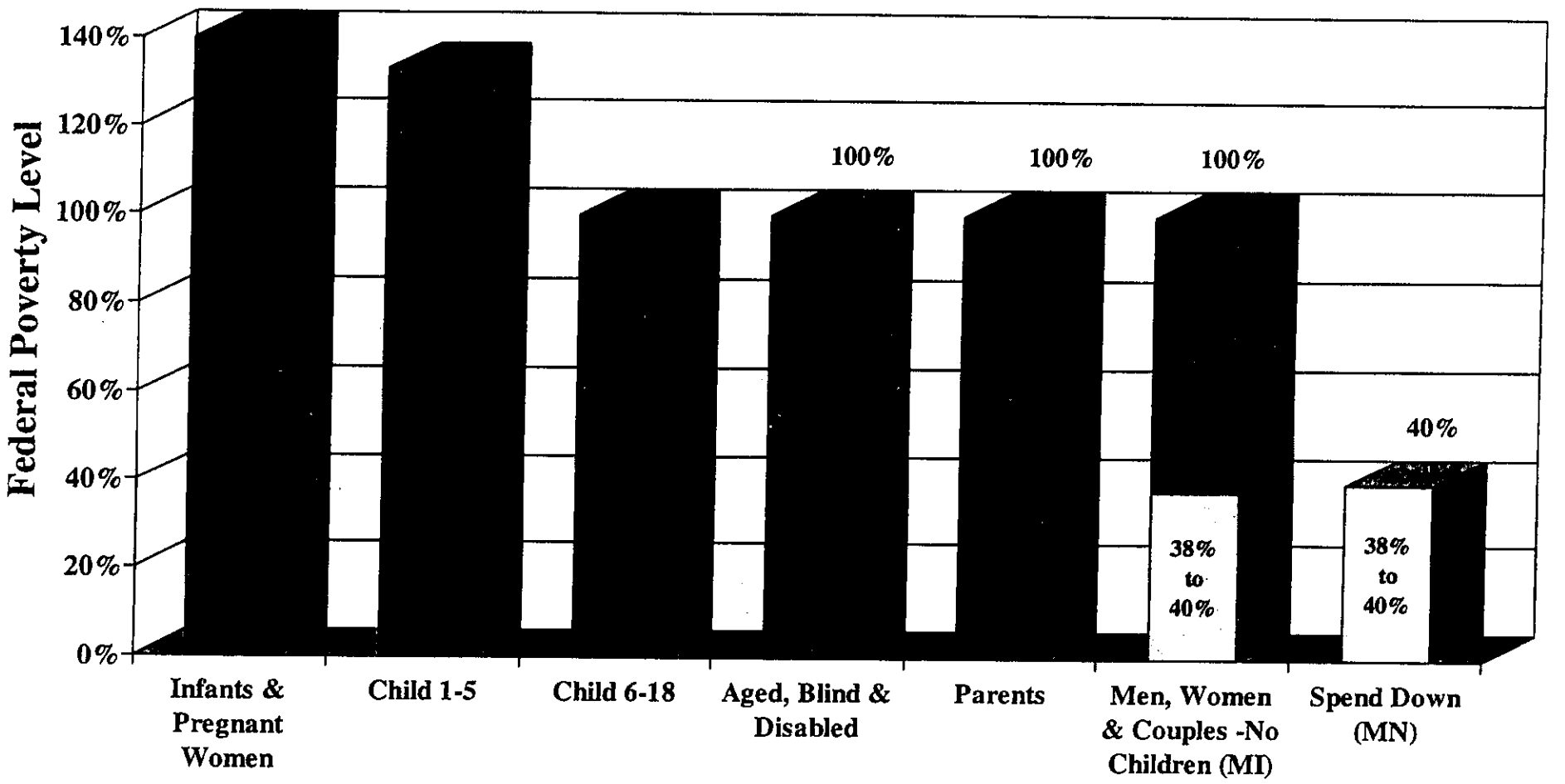
January 4, 2001

2000 Annual Income Standards

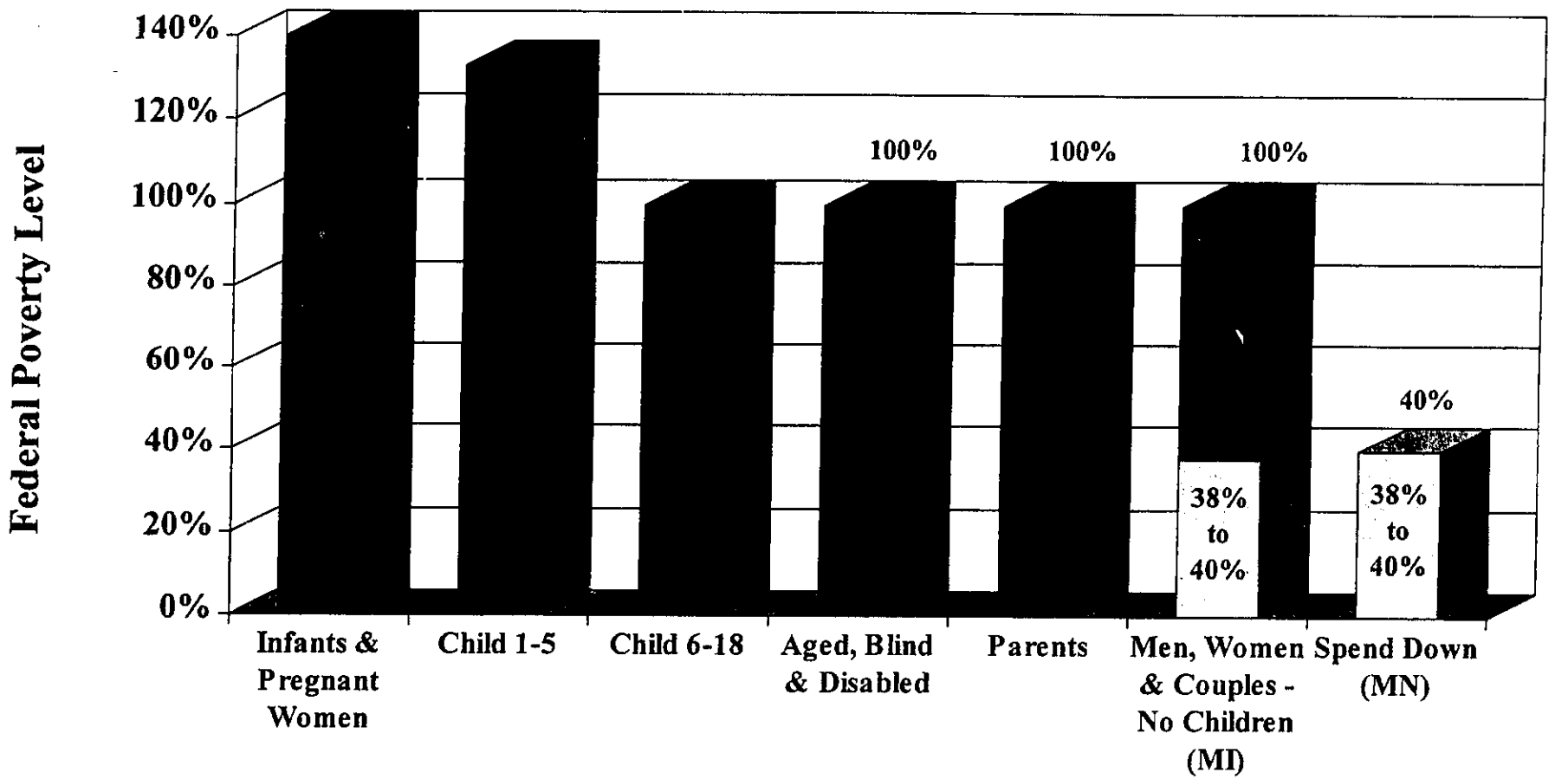


AHCCCS

Proposition 204 - Changes in FPL Standards



Who is Eligible?



Research and Analysis of Population, Health Care Program Utilization, Access to Providers and Cost to Provide Care through State Funded and/or Administered Programs

Executive Summary

Steven P. Schramm and
Michelle Taylor-Brklacich

January 5, 2001

WILLIAM M. MERCER

Attachment II. C

Purpose and Goals

For current or additional state funded or administered health care programs:

- Determine need for expansion
- Identify the populations with greatest potential need
- Assess utilization and costs related to current

Context

Focused on Four Programs to Address Uninsurance:

- AHCCCS - Low Income Pregnant Women and Children
- Prop 204 - Low Income Adults/Parents
- PSP - Working Poor
- HCG - Small Employers

Key Findings

Population Distribution Varies by County

% of Total Population

	Sample Counties					
Age Group	Apache	Coconino	Maricopa	Mohave	Pima	Yuma
19 and Under	***43.3%***	36.1%	29.7%	23.9%	28.6%	33.0%
20 – 29	12.6%	16.8%	14.2%	***8.7%***	13.9%	13.7%
30 – 39	14.1%	16.0%	15.6%	12.1%	15.3%	13.6%
40 - 49	12.1%	14.1%	14.8%	13.7%	14.1%	11.5%
50 - 59	8.0%	8.2%	9.9%	13.4%	9.8%	9.0%
60 - 64	2.7%	2.7%	3.6%	6.7%	3.9%	3.9%
65 and Above	7.3%	***6.2%***	12.2%	21.4%	14.4%	15.2%

Household Income Varies Widely by County and Age

Age Group with Highest Uninsurance Rate: 25 to 34

	Sample Counties					
Income Level	**Apache**	**Coconino**	**Maricopa**	**Mohave**	**Pima**	**Yuma**
$0 - $14,999	***50.5%***	28.1%	17.0%	20.0%	27.3%	21.5%
$15,000 - $24,999	21.1%	22.1%	20.5%	25.1%	24.2%	***28.6%***
$25,000 - $34,999	13.2%	22.1%	20.2%	22.2%	19.5%	22.2%
$35,000 - $49,999	10.0%	17.8%	22.5%	20.0%	17.8%	16.2%
$50,000 and above	5.1%	9.9%	***19.7%***	12.8%	11.2%	11.4%

Large Number of Small Firms in Arizona

Employment by County and Size of Firm

% of Firms

Size of Firm (# of Employees)	Sample Counties					
	Apache	Coconino	Maricopa	Mohave	Pima	Yuma
1 - 4	48.0%	53.5%	***59.3%***	55.6%	55.9%	53.2%
5 - 9	17.6%	19.8%	15.3%	19.4%	18.1%	***20.1%***
10 - 19	14.5%	12.8%	11.0%	13.5%	12.2%	12.0%
20 - 49	8.9%	9.1%	8.1%	7.4%	8.1%	8.7%
50 – 99	5.4%	2.7%	3.1%	2.6%	2.9%	3.2%
100 – 249	3.3%	1.6%	2.1%	0.9%	2.0%	2.0%
250 – 499	***1.5%***	0.3%	0.6%	0.6%	0.6%	0.6%
500 – 999	0.8%	0.1%	0.3%	0.1%	0.2%	0.3%
1,000+	0.0%	0.1%	0.2%	0.0%	0.2%	0.0%

Unemployment Varies by County

Unemployment by County -
Average January to May 2000

County	Unemploy %	County	Unemploy %
■ Apache	3.8%	■ Mohave	4.0%
■ Cochise	4.7%	■ Navajo	5.7%
■ Coconino	4.3%	■ Pima	2.8%
■ Gila	4.7%	■ Pinal	3.9%
■ Graham	5.8%	■ ***Santa Cruz***	***9.0 %***
■ Greenlee	6.7%	■ Yavapai	2.8%
■ La Paz	5.8%	■ ***Yuma***	***22.2%***
■ ***Maricopa***	***2.5%***	■ Statewide	3.3%

Differences Between State-Funded and Commercial Insurance Programs - Target Markets

- AHCCCS targets lower income people with medical needs
- Premium Share Program developed for the working poor or the notch group that does not qualify for AHCCCS
- Health Care Group was developed for the Small Employer who was having difficulty securing insurance coverage
- Commercial insurance hopes to attract "the young and healthy"

Differences Between State-Funded and Commercial Insurance Programs - Utilization

- State funded programs have higher hospitalizations per 1,000 members than Commercial programs*
  - AHCCCS-TANF ranges from 134.1 to 184.4**
  - HCG - 105.6
  - PSP General Population - 158.0
  - PSP Chronically Ill - 211.0
  - Arizona Commercial HMOs range from 45.7 to 55.6

*Based on most recent full year reported

**AHCCCS discharges are elevated due to very large numbers of deliveries

Access to Hospital Care and Physicians Varies by County

Hospital Beds and Physicians per 1,000 Population

	Sample Counties					
	Apache	Coconino	Maricopa	Mohave	Pima	Yuma
Population	68,782	114,171	2,784,075	130,618	790,755	132,259
Number of Hospital Beds	83	351	7,696	465	2,591	304
Hospital Beds per 1,000 Population	***1.2***	3.1	2.8	3.6	3.3	2.3
Number of Physicians	36	259	5,917	164	2,188	170
Number of Physicians per 1,000 Population	0.5	2.3	2.1	1.3	***2.8***	***1.3***

Cost to Provide Care through State Funded or Administered Programs Varies

- Per Member Per Month (pmpm) cost for most recent full year reported
  - AHCCCS (TANF only) - $115.79
  - HCG - $148.85
  - PSP General Population - $229.25
  - PSP Chronically Ill - $874.93

Urban, Semi-Rural and Rural Populations Have Different Problems

Issue	Urban*	Semi-Rural**	Rural***
Large # of Small Employers	X	X	X
High % of Households with Low Income			X
Access to Care		X	X
Lack of Insurance Carriers			X
High Unemployment			X
Superman Effect	X	X	X

*Urban refers to Maricopa, Pima and Pinal counties

**Semi-rural includes Coconino and Yavapai counties

***Rural includes Apache, Cochise, Gila, Graham, Greenlee, La Paz, Mohave, Navajo, Santa Cruz, and Yuma

Different Solutions Needed for Different Areas and Populations

ARIZONA STATE SENATE
RESEARCH STAFF

JASON BEZOZO
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STAFF DIRECTOR
HEALTH COMMITTEE
Telephone: (602) 542-3171
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TO: MEMBERS OF THE STATEWIDE HEALTH CARE INSURANCE PLAN TASKFORCE

DATE: May 14, 2001

H.B. 2164 – retirees; health insurance subsidies

Increases the health care premium subsidy for members of the Arizona State Retirement System, Public Safety Personnel Retirement System, Corrections Officer Retirement Plan and Elected Officials' Retirement Plan in all geographic areas. A similar bill, Senate Bill 1107 – retirees; health insurance; subsidies increases the health care premium subsidy for members in each retirement system in areas where no managed care program is available.

H.B. 2238 – tobacco tax allocation; detoxification services

Appropriates, subject to the availability of monies, $375,000 annually from the medically needy account for detoxification services in counties with a population under 500,000. Eliminates the pilot status of the detoxification program.

Appropriates $7 million in FY 2001-2002 from the medically needy account to AHCCCS to offset losses associated with Healthcare Group.

Continues the telemedicine program in FY 2001-2002 and FY 2002-2003.

Appropriates $200,000 in FY 2001-2002 and FY 2002-2003 from the medically needy account to DHS to distribute to specified counties for public health services.

Appropriates $125,000 in FY 2001-2002 to the University of Arizona to expand the Arizona telemedicine program.

Appropriates $1.5 million in each of FY 2001-2002 and FY 2002-2003 to DHS for non-title XIX children's behavioral health services.

Allows DHS to use $2 million of the $8 million annual medically needy account appropriation to DHS for psychotropic medications for non-title XIX behavioral health services.

H.B. 2243 – school employees; state health insurance

S.B. 1118 – prescription drug coverage

S.B. 1118 creates a two-year prescription drug subsidy pilot program under the administration of AHCCCS. In order to qualify for the pilot program, a person must be eligible for Medicare, have income between 100% and 200% federal poverty ($8,590 to $17,180), and be a resident of either a county without a Medicare HMO or with a Medicare HMO that does not provide prescription benefits. The program covers one-half of the cost of an eligible person's prescription medication that exceeds a required deductible. The deductible for persons between 100 and 150% FPL is $500 per year; for persons between 150 and 200% FPL, the deductible is $1,000 per year. In addition, the legislation appropriates $8.8 million over the next two fiscal years from the medically needy account to the AHCCCS administration for the medication subsidies and program administrative costs.

S.B. 1201 – appropriation; rural ambulances

This bill appropriates $1.5 million in FY 2001-2002 from the emergency medical services operating fund to the Department of Health Services to improve emergency medical services in rural areas.

S.B. 1209 –loan repayment; primary care providers

Allows a mid-level service provider to serve for more than two years under a contract for either the primary care provider repayment program or the rural primary care provider loan repayment program. Mid-level service providers include nurse practitioners, certified nurse mid-wives and physician assistants.

JB/ac

Arizona Statewide Health Insurance Planning Grant: Summary

The AHCCCS Administration recently received from the U.S. Department of Health and Human Services – Health Resources and Services Administration (HRSA) a one year, $1.16 million dollar grant to develop plans for providing uninsured Arizonans with affordable, accessible health insurance. Through this grant, the state will be able to effectively augment and support the efforts of the Statewide Health Care Insurance Plan Task Force which has been charged with development of an affordable health care insurance plan for all Arizonan's.

In order to effectively carry out this grant, the AHCCCS Administration will not only work in close cooperation with the Task Force but will establish a Technical Advisory Committee, consisting of experts in the health care arena. Additionally, the Administration will contract with:

- National consulting firms to provide expertise in modeling and actuarial / financial analysis as well as information on national/international efforts to address health care coverage.
- Arizona Rural Health Office to collect information on the current Arizona insurance landscape as well as conduct focus groups on the proposed plan.

Implementation of the HRSA grant, which runs from March 2001 through February 2002, will consist of the following key tasks:

- Establishment of Project Staffing and Organizational Framework: includes assignment of specific roles and responsibilities, appointment of the advisory committee and defining the principles for health care coverage in Arizona. (Primary responsibility of AHCCCS to be completed by 4/30/01)
- Research, Analysis and Preparation of the Health Insurance Report: includes compilation of Arizona specific information on coverage trends, health benefit coverage profiles, status of Arizona's insured population. (Primary responsibility of RHO to be completed by 12/4/01)
- Modeling Analysis: includes defining initial framework for the models, conducting the analysis and developing model options. (Primary responsibility of AHCCCS to be completed by 12/4/01)
- Development of Basic Health Insurance Plan: includes review of model options and solicitation of public input. (Primary responsibility of Task Force with AHCCCS support to be completed by 10/1/01)
- Selection of "Plan(s)" to Implement: includes selection of preliminary plan, focus group input and finalization of plan and preparation of final Task Force and HRSA reports. (AHCCCS, Task Force and RHO involvement to be completed by 2/15/02)

In addition to the Task Force report which will set forth a framework for future healthcare coverage decisions as well as a recommended plan(s) to implement, the work associated with the HRSA grant will produce the following:

- Arizona Health Insurance Report which summarizes health insurance coverage and cultural issues and provides data on the current insurance situation in Arizona.
- Interim and Final Reports to HRSA which document the state's experience in examining the uninsured population and developing proposals to expand health insurance coverage.

E. Project Management Matrix

Action Steps	Timetable	Responsible Agency	Anticipated Results	Evaluation/ Measurement	Process for Collaboration
Task 1: Project Staffing and Organization					
Determine roles/responsibilities of staff/consultants	3/1/01-4/30/01	AHCCCS	Staff hired and consultants contracted with by 3/30/01	All staff/consultants on board by 3/30/01	**AHCCCS** and state agencies, RHO
Appoint Technical Advisory Committee	3/15/01-4/15/01	AHCCCS	Advisory committee will be selected and in place by 4/15/01	Advisory committee appointed by 4/15/01	Community leaders and agencies, consultants, RHO
Define Principles for Arizona Health Care Coverage	4/2/01-4/30/01	AHCCCS/ Task Force	Listing of Task Force Principles for Arizona Health Care Coverage by 4/30	Principles for Arizona Health Care Coverage by 4/30	Task force, consultants, AHCCCS
Task 2: Background Research, Data Collection and Analysis for Health Insurance Report					
Define initial framework for the report	3/15/01-4/30/01	RHO / consultants	Research areas defined and detailed workplan developed for initial research/analysis	Workplan in place by 4/30/01	AHCCCS, task force, advisory committee, consultants
Conduct research and analysis	3/16/01 – 11/4/01	RHO / consultants	Research conducted between now and end of the project	Research completed within required timeframes	AHCCCS, task force, advisory committee, consultants
Provide preliminary findings regarding individual/community surveys on health insurance coverage/cultural issues	6/15/01-7/15/01	RHO/consultants	Preliminary findings will be presented to AHCCCS and advisory committee	Preliminary findings reported to AHCCCS and advisory committee	AHCCCS, advisory committee
Prepare AZ Health Insurance Report	8/14/01 - 12/4/01	RHO / consultants	Report reviewed and finalized by 9/4/01	AZ Health Insurance report completed by 9/4/01	AHCCCS, consultants, advisory committee

E. Project Management Matrix (con't)

Action Steps	Timetable	Responsible Agency	Anticipated Results	Evaluation/ Measurement	Process for Collaboration
Task 2: Background Research, Data Collection and Analysis (con't)					
Present findings to advisory committee and task force	4/30/01 – 12/15/01	RHO / consultants	Presentations made to advisory committee and task force between 4/30/01 and 12/15/01	Presentations completed as scheduled/requested	AHCCCS, task force, advisory committee, consultants
Task 3: Model Analysis					
Define initial framework for the models	3/15/01-4/30/01	AHCCCS / consultants	Research areas defined and detailed workplan developed for initial research/analysis	Workplan in place by 4/30/01	Task force, advisory committee, consultants
Conduct research and analysis	Ongoing	AHCCCS / consultants	Research conducted between now and end of the project	Research completed within required timeframes	Task force, advisory committee, consultants
Develop model options	Ongoing	AHCCCS / consultants	Models reviewed and finalized	Models completed	Consultants, advisory committee
Present findings to advisory committee and task force	4/30/01 – 12/15/01	AHCCCS / consultants	Presentations made to advisory committee and task force between 4/30/01 and 12/15/01	Presentations completed as scheduled/requested	Task force, advisory committee, consultants

E. Project Management Matrix (con't)

Task 4: Development of Basic Health Care Insurance Plan					
Examine basic health care insurance plans	5/7/01 – 10/26/01	Task Force	Task force meetings scheduled and conducted to review options and relevant background information by 10/26/01	Health insurance plans evaluated by 10/26/01	Task force will work with AHCCCS, advisory committee and consultants
Hold public hearings/community meetings regarding the plans	6/1/01-9/14/01	Task Force	Meetings scheduled and conducted to get public input by 9/14/01	Public input obtained by 9/14/01	Task force will obtain information from all interested parties
Prepare interim report to HRSA	10/1/01 – 10/26/01	AHCCCS	Report prepared, reviewed and submitted to HRSA by 10/26/01	Interim report completed by 10/26/01	Advisory committee, consultants, RHO
Task 5: Final Selection of "Plan" to Implement					
Develop preliminary recommendation	9/14/01 – 10/26/01	Task Force	Preliminary plan developed by task force	Plan ready for public input by 11/16/01	Task force will work with AHCCCS, advisory committee and consultants

E. Project Management Matrix (con't)

Action Steps	Timetable	Responsible Agency	Anticipated Results	Evaluation/ Measurement	Process for Collaboration
Task 5: Final Selection of "Plan" to Implement (con't)					
Test new plan through focus groups	10/26/01 – 11/16/01	RHO	Focus groups conducted and results presented to task force by 11/16/01	Results from focus groups presented to task force by 11/16/01	AHCCCS, task force, advisory committee, consultants, community agencies
Finalize task force report	11/16/01 – 12/15/01	Task Force	Preliminary recommendations refined and final report prepared by 12/15/01	Report completed by 12/15/01	Task force will obtain input from all involved groups
Prepare final report to HRSA	1/7/02 – 2/15/02	AHCCCS	Final report prepared, reviewed and submitted to HRSA by 2/15/01	Report completed by 2/15/02	Advisory committee, consultants, RHO

Project Schema HRSA

Statewide Task Force

Role
- Design a framework for healthcare coverage decisions
- Recommend a "plan" to implement.

Technical Advisory Board

Role
- Source for Developing plan options
- Feedback on Task Force ideas

ROLE
- HRSA Relationship
- Policy Maker Relationship
- Coordinate Direct Consultants & RHO
- Resource for Task Force
- Develop & Staff Advisory Board

CONSULTANTS (NAT'L INFO)
- National/International Information on Coverage
- Models in Healthcare Coverage
- Other states experience
- Actuarial and other business estimates
- Payment/Financing options

RHO (ARIZONA INFO.)
- Surveys on Health Ins Coverage/Cultural Issues
- Collection and review of existing data on current insurance situation in AZ
- Providers views
- Testing of new plan through focus groups

4-6-01

AHCCCS

Proposition 204

Expanding Health Care Coverage

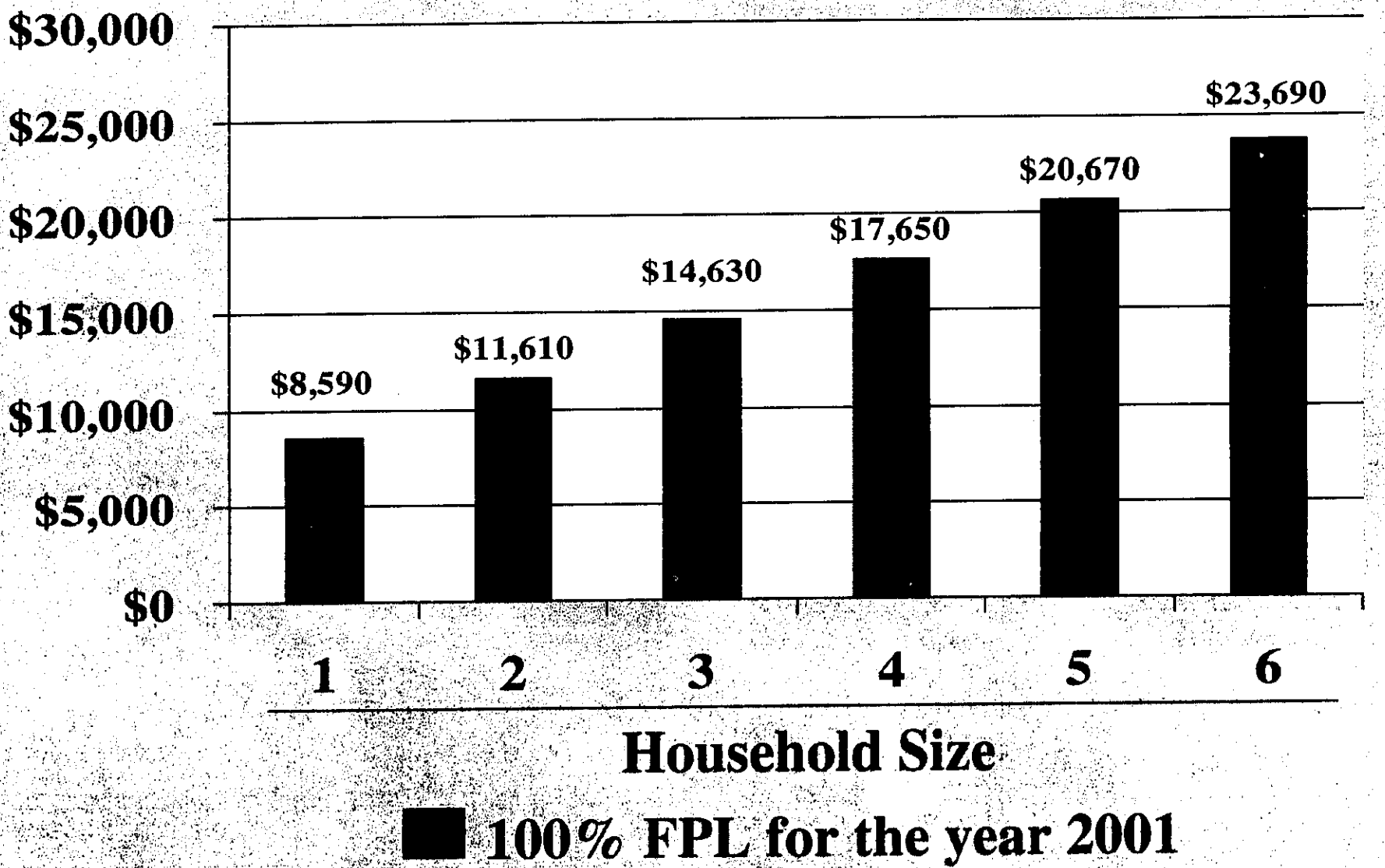
March 16, 2001

Attachment III. C

Intent

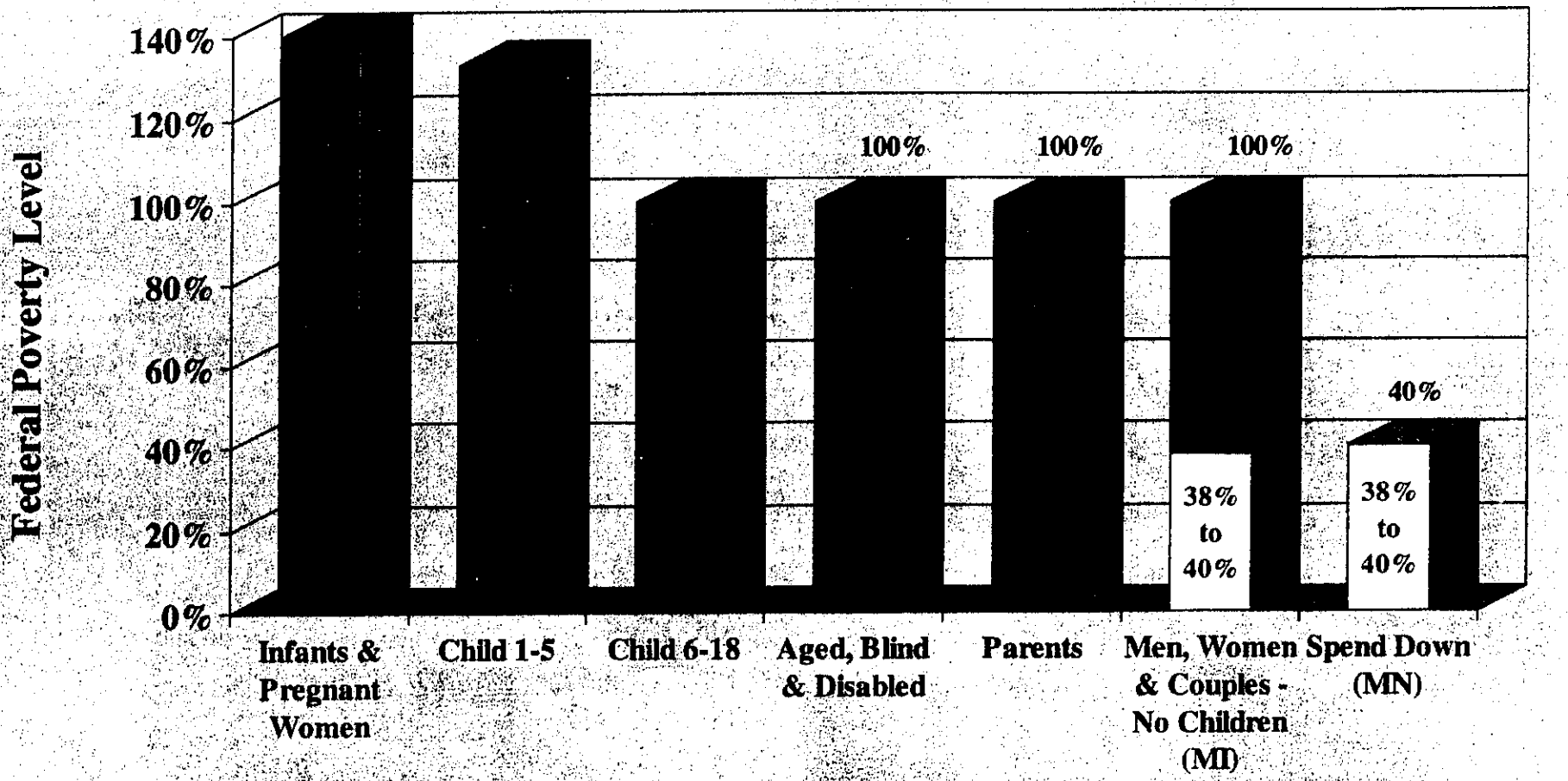
- To increase Medicaid coverage up to 100% of FPL
- To fund 6 other programs:
  - Healthy Families
  - Arizona AHEC
  - Teen Pregnancy
  - Health Start
  - Arizona Disease Control Research
  - Women, Infants, and Children's Food Program
- "Other programs to benefit the health of the residents of this State"

2001 Annual Income Standards



March 16, 2001

Who is Eligible?



Phase-In Schedule

4/1/01

	Estimate
Convert state-funded populations (EAC, ELIC, MN/MI, SES)	18,000
Add aged, blind, and disabled up to 100% FPL*	27,000

7/1/01

[redacted]

10/1/01

[redacted]

***Additional 47,000 aged, blind, and disabled may enroll**

Population Estimates

- Number of new adults up to 100% of FPL eligible due to Proposition 204 - 382,000
  - 186,000 are uninsured
  - 196,000 are insured (Medicare*, Military or Private insurance)

*Medicare woodwork population is approximately 47,000

Legislation

- Eligibility issues
- County role in health care
- Funding mechanisms

Key Changes

HB 2585 - Premium Sharing Program (PSP)

HB 2238 - Tobacco Tax Allocation for HealthCare Group (HCG)

HB 2585 - KidsCare Parents

HB 2585 - PSP

- Makes PSP a permanent statewide program for persons with income up to 250% of FPL.
- Appropriates $5 million in FY 01-02 and $20 million per year beginning July 1, 2002 in tobacco tax funds.
- Current enrollment is 7,748
- Approximately one-third of the current enrollees will be eligible for the Proposition 204 expansion.

HB 2238 - HCG

- In FY 2001-02, $7m from medically needy account for HCG for one year.
- Healthcare Group is for small employers with up to 50 employees and the self-employed.
- Average group size is 3.2
- Current enrollment is 11,987

HB 2585 - KidsCare Parents

- Requires AHCCCS to submit a waiver for parents of children enrolled in KidsCare.
- Estimated enrollment is expected to be about 32,000 parents.
- Will need state match of approximately $8.7m the first year

Statewide Health Care Insurance Plan Taskforce
Process for the Development of Guiding Principles
Agenda Item 5.
May 14, 2001

I. Introduction of Facilitator

Dave Griffis will facilitate this portion of the meeting. His biographical information is attached.

II. Ground Rules for Today's Meeting

Mr. Griffis will assist the Taskforce in developing ground rules for today's discussion.

III. Desired Outcomes for Today

A. Develop a list of guiding principles against which future Taskforce decisions can be measured.

B. Using the guiding principles, develop broad-based evaluation criteria against which Taskforce proposals and models can be evaluated.

C. Explore the interrelated systems, issues, and concerns that impact overall project outcomes and goals.

IV. Principles

The purpose of developing the principles is to help the Taskforce, the HRSA Grant team, and related staff to maintain direction and focus.

A. Short Form Principles from Taskforce Tree Diagram

The tree diagram was originally presented to the Taskforce at its meeting of January 5, 2001.

1. Availability
2. Affordability
3. Basic Benefits
4. Seamless System
5. Public/Private Partnership

B. Examples of Long Form Principles

These sample principles are based, in part, on similar work done by HRSA grant recipients in other states.

1. All Arizonans, in both rural and urban areas of the state, should have access to basic and affordable health care, regardless of their financial or employment status.
2. Providing access to health care is a shared responsibility involving providers; insurers; employers; and, under some circumstances, government.
3. Where subsidies must be provided to make health care affordable, they should be based on the ability to pay.

4. Integration and consistency should be maintained among the publicly supported programs in regards to benefits, eligibility and cost-sharing.

C. Taskforce Draft One Principles

Mr. Griffis will facilitate a discussion of the Taskforce around these and other guiding principles that Taskforce members believe are important.

V. Principle-based Evaluation Criteria

The purpose of evaluation criteria is to give the Taskforce a method for systematically sifting and evaluating potential proposals, initiatives, and models.

Once options for final recommendations are developed, the extent to which they meet the evaluation criteria, should help with Taskforce decision-making and the development of a final report.

A. Sample criteria for discussion.

These sample criteria statements are based, in part, on similar work done by HRSA grant recipients in other states.

1. Does it make a substantial impact on increasing access to health insurance?
2. Does it expand both public and private financing?
3. Is infrastructure in place to implement and to ensure long-term sustainability?
4. Is a stable and sufficient funding source available?
5. Does it strengthen rather than undermine employment-based coverage?
6. Does it ensure access to high quality care?
7. Does it avoid fragmented solutions and a piecemeal approach? Can it be tailored to address the specific needs of the target populations and local environs but designed within the context of a broader comprehensive system approach?
8. Can it be modeled and tested first before rolling it out to the entire state?
9. Will it effectively leverage federal, private and community based resources and maximize federal funding?
10. Does it provide for portability and continuous insurance, avoiding spells of no insurance coverage?
11. Will it keep families in a single insurance plan?
12. Will it avoid the welfare stigma that can deter enrollment in public programs?

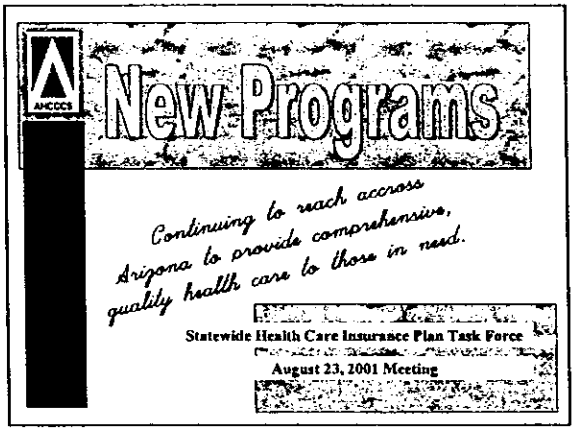
B. Taskforce Draft One Evaluation Criteria

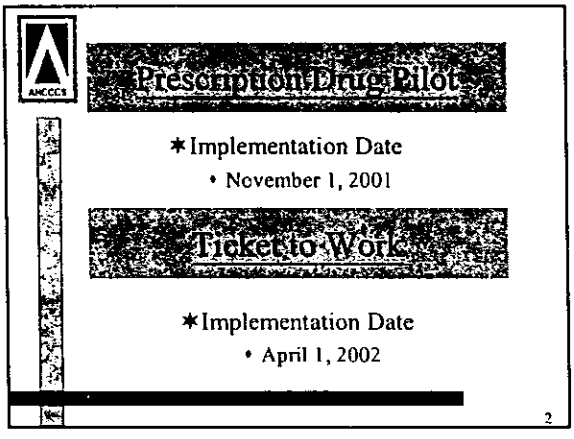
Mr. Griffis will facilitate a discussion of the Taskforce around these and other evaluation criteria that Taskforce members believe are important.

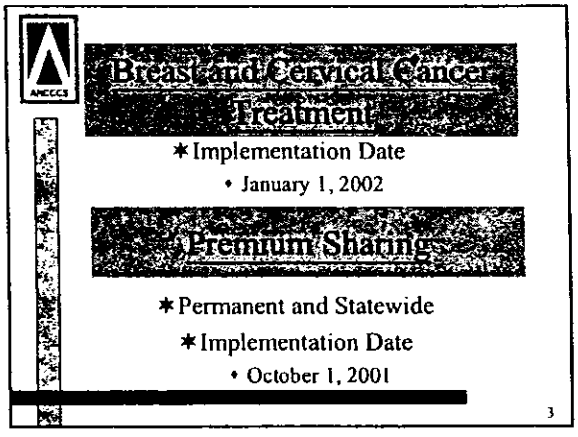
VI. Systems Thinking and the Project

If time allows Mr. Griffis will lead a discussion of the multiple interdependent constituencies, issues, and systems that are potentially impacted by the Taskforce's work. This conversation will be linked to the Taskforce's deliberations around principles and evaluation criteria.

VII. Return Meeting to Cochairs for Final Comments and Adjournment


New Programs
Continuing to reach accross Arizona to provide comprehensive, quality health care to those in need.
Statewide Health Care Insurance Plan Task Force
August 23, 2001 Meeting


Prescription Drug Pilot
*Implementation Date
• November 1, 2001
Ticket to Work
*Implementation Date
• April 1, 2002
2


Breast and Cervical Cancer Treatment
*Implementation Date
• January 1, 2002
Premium Sharing
*Permanent and Statewide
*Implementation Date
• October 1, 2001
3

Finger Imaging

* Implementation Date
  - October 1, 2001

Kids Care Changes

* Implementation Date
  - October 1, 2001

4

Prop 204 Implementation

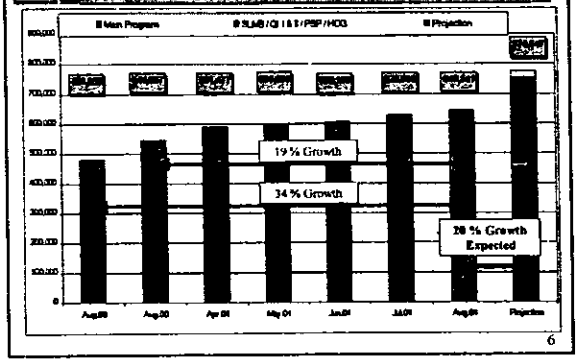
* Implementation Date
  - October 1, 2001

Interim Committees

* Hospital Reimbursement Study
* Proposition 204 Oversight
* Premium Sharing Oversight

5

Historical AHCCCS Enrollment



6

Attachment A

Statewide Health Care Insurance Task Force: Draft Guiding Principles

The Arizona Statewide Health Care Insurance Task Force has tentatively defined six (6) principles to guide its deliberations. These guiding principles are listed below along with a set of questions (criteria) to be answered when developing issue papers and health care models. The attached drawing (Attachment 1) summarizes these principles and restates four fundamental beliefs of the Task Force.

We should seek to make available Basic Benefits.

- Are the basic benefits (i.e., service coverage and limitations) clearly defined?
- Are the sub-populations eligible for coverage clearly defined including the coverage (or non-coverage) of non-US citizens?
- Are prevention services that will save money included as part of the basic benefit package? Can they be quantified?
- Will the benefit package provide the opportunity for improvement in health status and the delivery of quality care?
- Is the basic benefit package portable?
- What is the value (i.e., return on investment) of the basic benefit package?
- Does the package contain the appropriate incentives to support the guiding principles?

Health Care should be Available and Accessible.

- Are the right services (plans and providers) available in the right places at the right times?
- Are there incentives in place to encourage providers to provide services where needed?
- Will consumers (e.g., employers, employees, non-employed individuals) use the services, i.e., minimal barriers and appropriate incentives?
- Do commercial carriers have the incentive to participate?

Health Care should be Affordable and Properly Financed.

- Have the cost been clearly identified, both short and long term?
- Have the associated financial risks been clearly identified?
- Can the State afford it? Can members afford it? Can carriers afford to offer it?
- Can the costs be appropriately managed?

- Is it financially self-sustaining and solvent over the long term?

Health Care should be provided through a Seamless System.

- Do pieces of the system fit together well minimizing fragmentation and duplication? Does interdependence and coordination exist between system pieces?
- Have the interrelationships between various programs been taken into consideration such as those sponsored by Title XIX/XXI, Mexican government, Indian Health Services.
- Is one stop shopping made possible in as many situations as practical?
- Are services/care coordinated including the ability to easily move from primary care to specialty?
- Is there the flexibility and adaptability to move pieces around?
- Does the system encourage the highest and best use of services?
- Does a continuum of services exist as the population ages?
- Is the model administratively simple, i.e., low on paperwork and low on hassles?

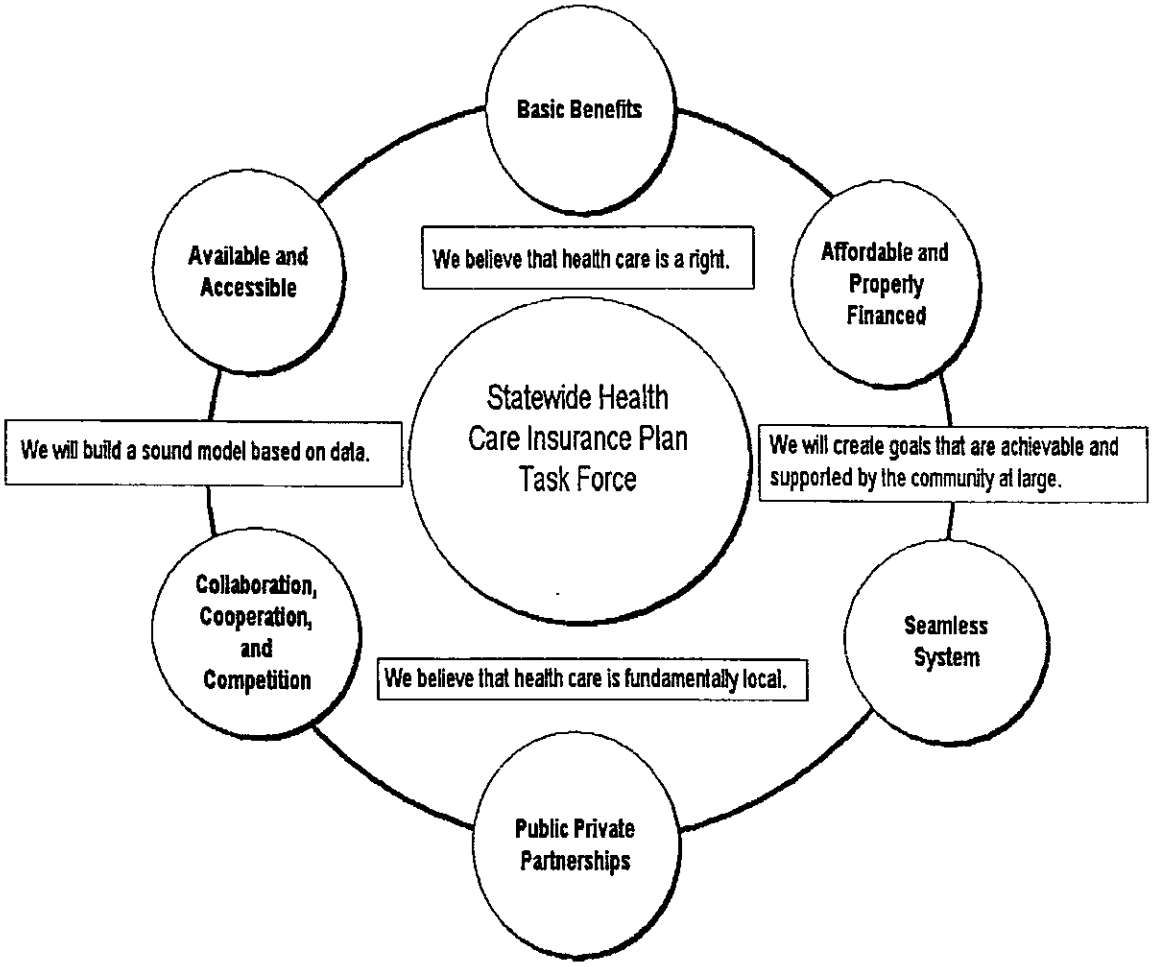
Health Care should be done in Collaboration and in Cooperation with the various stakeholders both public and private sector and it should foster Competition.

- Is there provider acceptance to the approach?
- Does it create an atmosphere that fosters competition, collaboration, and cooperation especially beyond primary care?
- Has the government's role in facilitating competition been made clear?
- Does it provide a way for dealing properly with providers?
- Does it encourage a better-informed consumer?

Public Private Partnerships should be sought.

- Do the State's educational institutes, e.g., College of Medicine, Community Colleges, and other allied health-training program have a clearly defined role in supporting the system?
- Have the appropriate linkages to employers been established?
- Does the model have adequate links to economic / workforce development?
- Are commercial carriers involved in the model?

Attachment 1: Summary of Principles and Fundamental Beliefs



ARIZONA HRSA STATE PLANNING GRANT WEB SITE

http://www.ahcccs.state.az.us/Studies/default.asp?ID=HRSA

1. Go to the AHCCCS Home Web Site, which is **http://www.ahcccs.state.az.us**
2. Find the yellow heading "**Resources**" in the blue left-hand column
3. Under this heading, click on "**Studies**"
4. Click on "**More**" under the "**Arizona Statewide Health Insurance Planning Grant**"

- **Summary of the Grant**
- **06/28/01 Status Report**
- **Draft Guiding Principles**
- **Summary of Principles and Fundamental Beliefs**
- **Southwest Border Rural Health Center: Project Summary**
- **Technical Advisory Committee**
- **Contacts**
- **Arizona and Federal Links**

AHCCCS

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AHCCCS

Statewide Health Care Insurance Plan Task Force

Arizona State Planning Grant:

Strategies to Increase Access to Health Care in Arizona

Steven P. Schramm, Principal
William M. Mercer, Incorporated

August 23, 2001

WILLIAM M. MERCER

Statewide Health Care Insurance Plan Task Force

Arizona State Planning Grant:

Strategies to Increase Access to Health Care in Arizona

Steven P. Schramm, Principal
William M. Mercer, Incorporated

August 23, 2001

WILLIAM M. MERCER

Attachment IV D

Context

Arizona Programs/Focus to Address Uninsurance:

- AHCCCS - Low-Income Pregnant Women and Children
- Prop 204 - Low-Income Adults/Parents
- Premium Sharing Program - Working Poor
- Health Care Group - Small Employers

Identification of Sub-Populations

Drivers of the Uninsurance Rate:

- Age
- Income
- Ethnicity
- Employment Status
- Geography

Identification of Sub-Populations

Key Focus for Arizona Policy Makers - Strategies:

- Joint State/Federal Programs - e.g., Medicaid/SCHIP/Waivers
- State and Local Initiatives - e.g., Purchasing/Risk Pools
- Market-Based Reform - e.g., Subsidies/Tax Incentives

Identification of Sub-Populations

Key Focus for Arizona Policy Makers - Practical Strategies:

- Low-Income Uninsured Children and their Parents - Education and Outreach on Existing Programs
- Low-Income Hispanic Uninsured - Culturally Appropriate Approaches to Existing Programs
- Working Uninsured in Small Employers - Incentives to Improve Offering and Take-Up Rates
- Rural Low-Income Uninsured Children and their Parents - Community Specific Education and Outreach

Strategies to Improve Rural Access to Health Care

Key Focus for Arizona Policy Makers - Barriers:

- Lack of Physicians and Other Providers - Every Arizona County except La Paz has an Officially Recognized Medically Under-Served Area
- Geographic Isolation - Fewer Resources for Providers
- Hospital Solvency - Insufficient Volume to Justify Size and Capabilities

Critique of Proposed Basic Benefit Package

Key Focus for Arizona Policy Makers - Forms of Insurance:

- Catastrophic Insurance - Protect Assets from Large Expenses
- Indemnity - Initial Deductible followed by Coinsurance
- Pre-Paid Insurance - Focus on Preventive to Avoid More Costly Care Later

Critique of Proposed Basic Benefit Package

Key Focus for Arizona Policy Makers - Proposed Benefit Plan:

Arizona Basic Health Benefit Plan as a Starting Point

- Not Basic
- Not Targeted at the Uninsured
- Not Affordable
- Not Attractive as Currently Available and Market Shows No Interest

Question and Answer

A MILLIMAN GLOBAL FIRM

Milliman USA

Consultants and Actuaries

Thomas D. Snook, FSA, MAAA
Principal and Consulting Actuary
Milliman USA, Inc.

Four Issue Papers

- Incentives and Regulatory Mandates
  - Tom Snook, Milliman – Phoenix
- Purchasing Pools
  - Shelly Brandel and Larry Pfannerstill, Milliman – Milwaukee
- High-Risk Pools
  - Scott Bentley and Dave Ogden, Milliman – Milwaukee
- Socialized Medicine
  - James Reed, Tim Barclay, and Will Fox, Milliman - Seattle

Incentives and Regulatory Mandates

- Looked at 3 areas:
  - Consumer-based initiatives
  - Health plan initiatives and mandates
  - Employer Mandates
- Focus is on *state* initiatives, not federal
- Focus is outside of Arizona
- Examine in light of Task Force criteria

Insurer Mandates

- Individual Insurance Market Reform
  - Varies widely by state
  - Some have been disastrous
  - None have been successful in reducing the uninsured population
- Rural health care coverage
  - Mandating inclusion of rural providers in networks

Employer Mandates

- Coverage mandates
  - Hawaii requires employers to provide health insurance (ERISA exemption)
  - Three states considered "pay or play"; none implemented
- Small group reform
  - Insurers and employers cannot exclude specific employees if otherwise eligible

Summary/Recommendations

- States are an experimental lab
  - Some successes
  - Some failures
  - A few catastrophes
- Affordability is the tough issue
- Programs most successful in directly reducing the number of uninsureds usually involve some expenditure of public funds
- Programs least successful:
  - Individual market reform
  - Tax credits

Purchasing Pools' Role in Reducing the Uninsured

- Need to increase substantial enrollment to be viable and lower prices at all
- Pools will not be able to lower prices enough to encourage more small employers to offer insurance without significant subsidies or mandates

High-Risk Pools

Major Roles of High-Risk Pools

- **Make coverage available to "uninsurable" individuals**
- **Reduce number of uninsured**
  - **"Affordable" premium to high risk individuals**
- **Can provide stability to market**
  - **Some studies imply help keep rates down**

Socialized Medicine

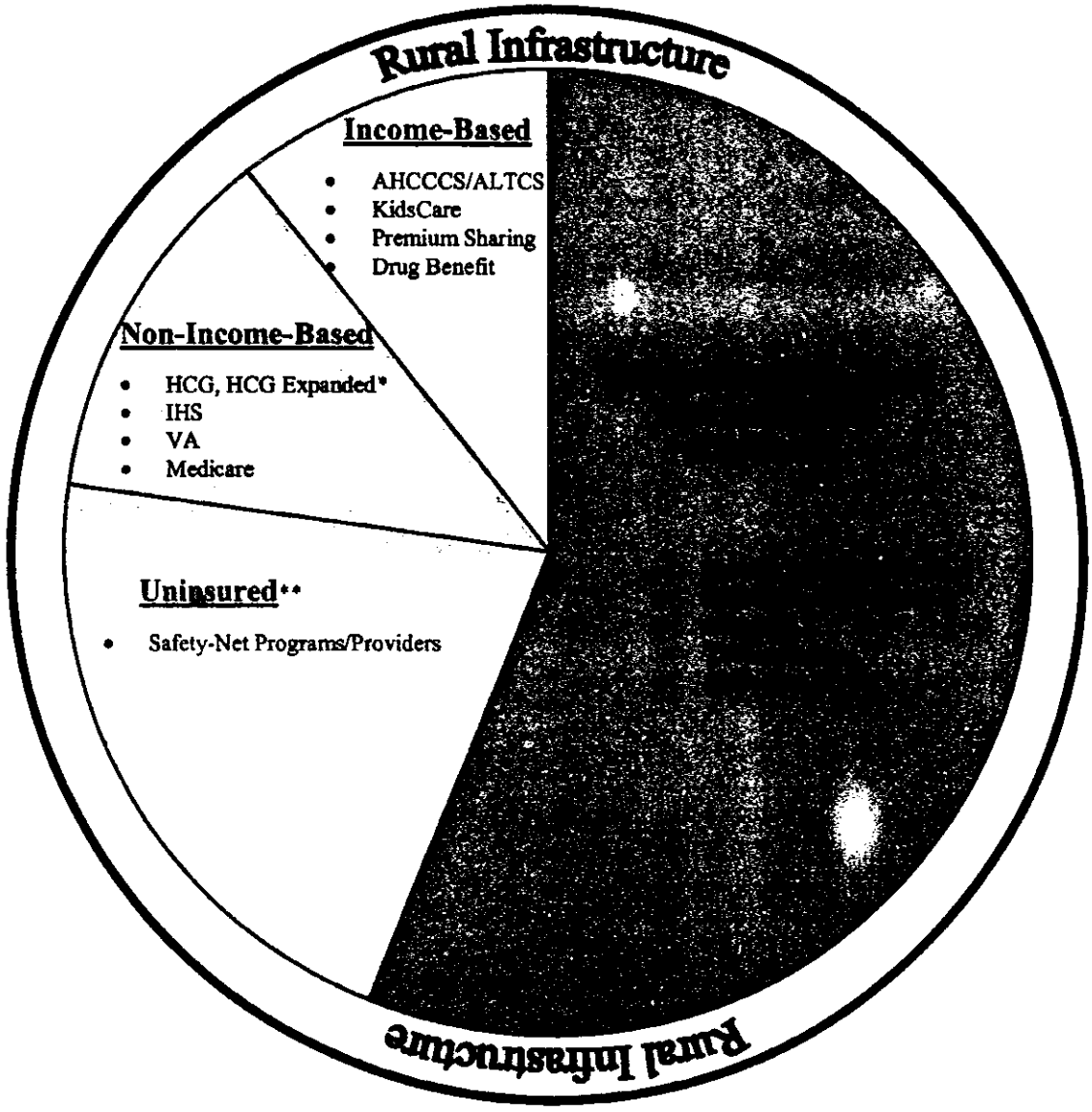
Common Characteristics of Social Insurance

- Solidarity: A compact for working individuals to provide insurance for poor, elderly, uninsureds
- Finance: Largely reliant on taxation; mandatory coverage paid by employers & employees
- Regulation: Highly regulated, whether single- or multi-payor system
- Prevention: Significant emphasis on health promotion and preventive care

Common Characteristics of Social Insurance

- Out-of-Pocket Expenses: Many require copays, often based on ability to pay
- Waiting Lists: Most ration care through waiting lists for non-acute surgeries
- Long-Term Care: Commonly recognized as a problem with coverage in its infancy
- Non-Citizens: Generally covered for emergency care, often allowed to purchase insurance in host nation

Health Coverage in Arizona



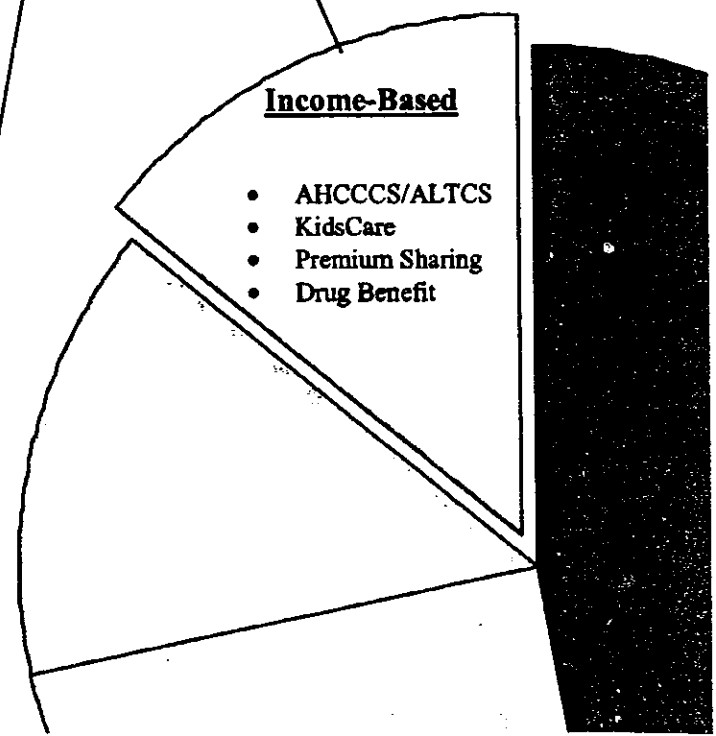
* = Proposed Programs being considered by the Task Force

** = Uninsured Characteristics:

- Rural Areas
- Small & Medium Employers
- Low-Income (not poor)
- Early Retirees
- Elligible, but not enrolled

Health Coverage in Arizona (Income Based)

Premium Sharing – Chronically Ill Only (limited to certain illnesses and maximum number of participants active at one time) – subsidized coverage			400% FPL
Premium Sharing (requires premium up to 4% of gross income) – subsidized coverage	Ticket to Work (limited to disabled returning to work – allows them to retain Medicaid benefits)	Breast and Cervical Program (under 65 and ineligible for other forms of Medicaid)	250% FPL
ALTCS – 300% SSI or 223% FPL			223% FPL
Kids Care (limited to children under 19)	Senior Pharmacy Benefit (limited to non-HMO counties – partial benefit)		200% FPL
Transitional Medical Assistance (TMA)			185% FPL
Medicare – Cost Sharing Programs (up to 175%)			175% FPL
AHCCCS Medicaid-Pregnant Women & Children Under Age 1 (SOBRA)			140% FPL
AHCCCS Medicaid - Children Ages 1-5 (SOBRA)			133% FPL
AHCCCS Medicaid – Various Programs Based on Income – Prop 204/Title XIX Waiver	Families and Children 1931	AHCCCS Medicaid – Children Ages 6-18	SSI Limited	100% FPL
AHCCCS Medicaid – Spend-down Group (medical expenses reduce gross income to 40% FPL)				40% FPL



Example 1: A family of 4 at 100% of FPL earns $17,050 annually

Example 2: A single individual at 100% of FPL earns $8,350 annually

Health Care Coverage in Arizona by Payor Source

Task Force: Strategies Under Consideration					
Current Strategies / Programs	• AHCCCS / ALTCS • KidsCare (≤ 150% of FPL) • IHS • VA* • Medicare*	• Premium Sharing • KidsCare (> 150% of FPL) • Prescription Drugs • Safety-Net Programs	• Health Care Group	• Employer Sponsored • Discount Programs	• Individually Purchased Services or Insurance
Payor Source	Public	Public / Individual	Public / Individual / Private	Individual / Private	Individual

* = These programs require some cost sharing by individual recipients

Income Eligibility Levels

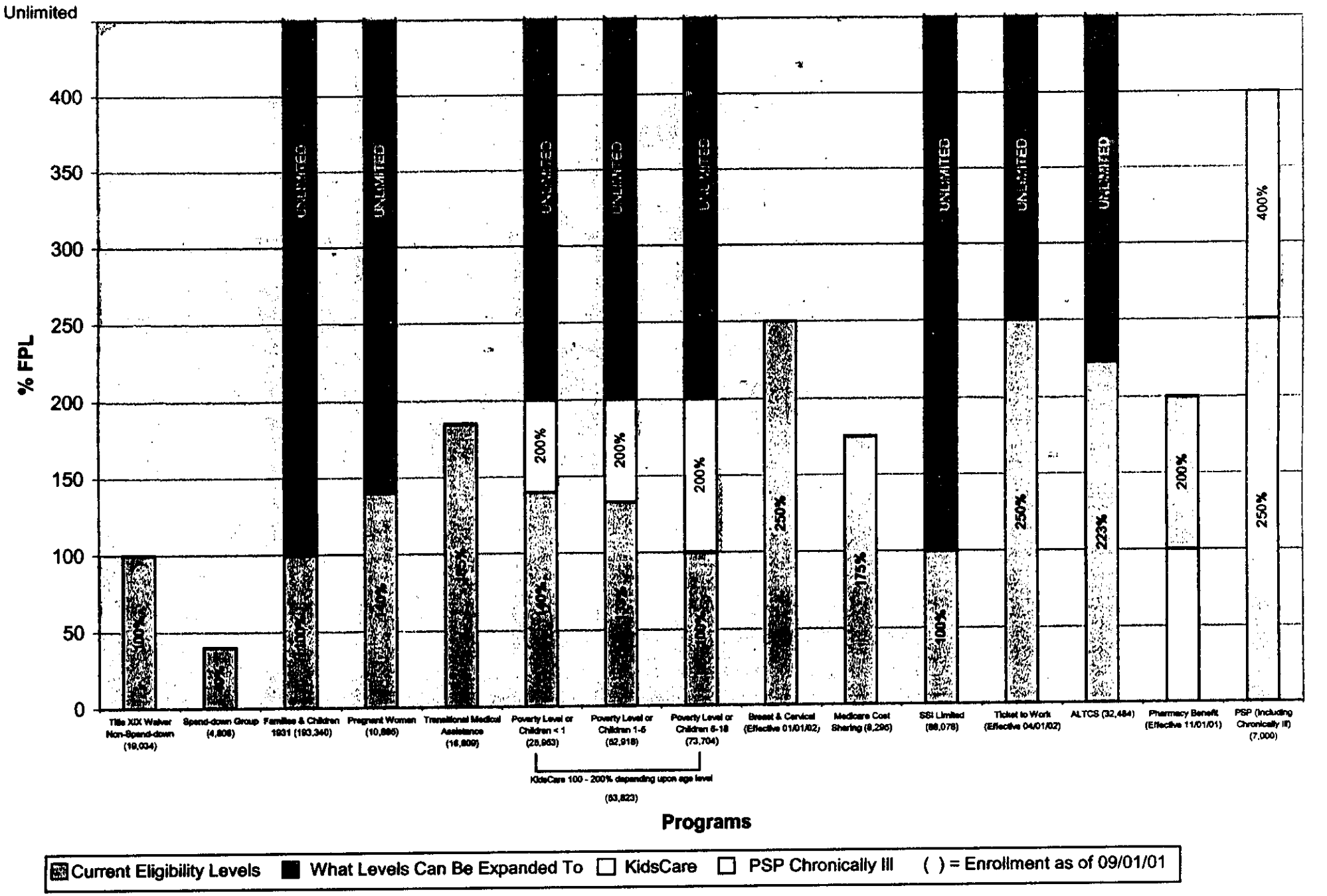
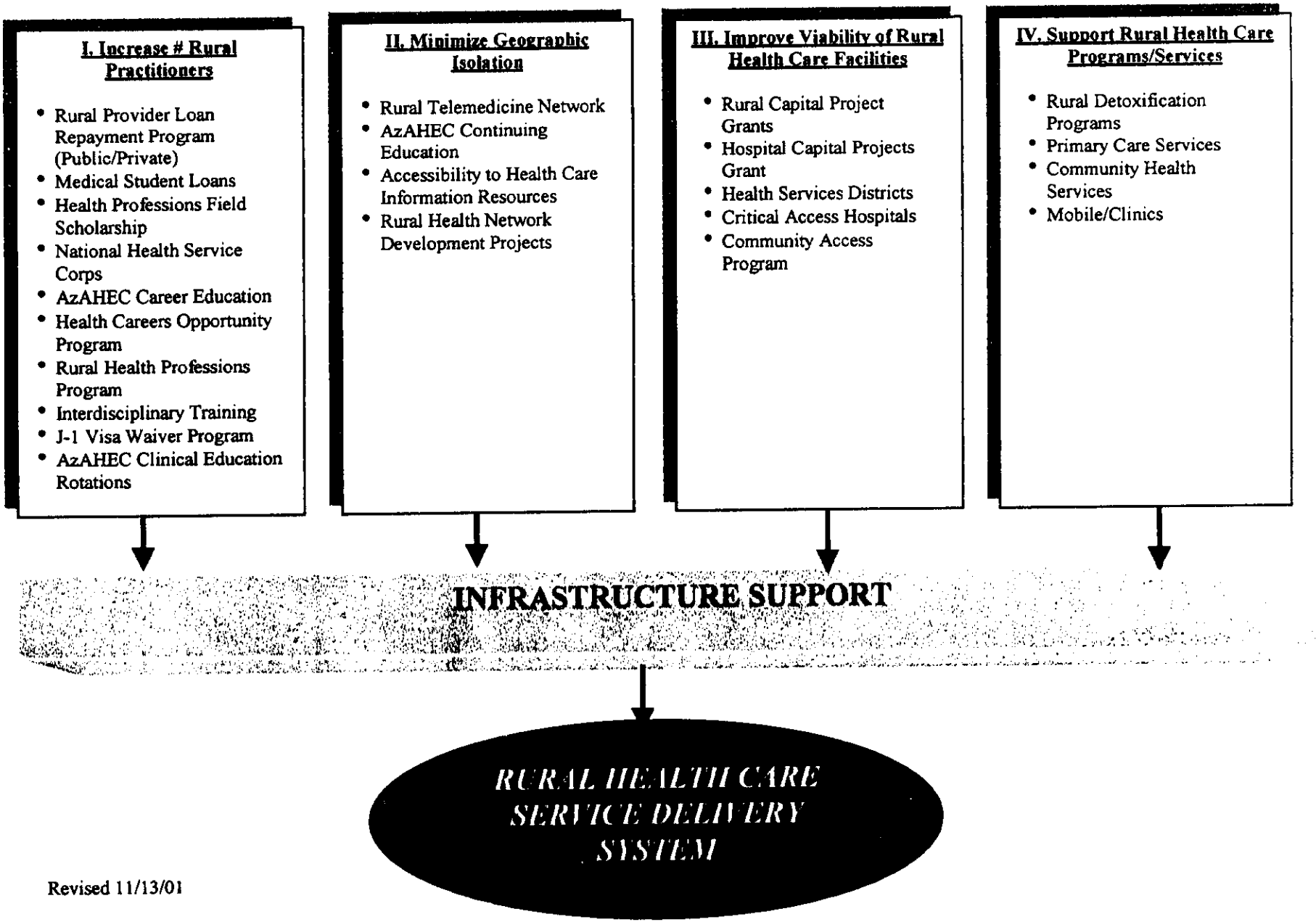


DIAGRAM 1: STRATEGIES TO IMPROVE RURAL HEALTH CARE DELIVERY IN ARIZONA



Revised 11/13/01

Statewide Health Care Insurance Plan Task Force

Arizona State Planning Grant:

Information Update from the Policy Papers

Steven P. Schramm, Principal
William M. Mercer, Incorporated

September 27, 2001

WILLIAM M. MERCER

Attachment V. B

Direction from the Task Force

Requested AHCCCS Provide Additional Information on:

- Sub-Populations—Uninsured Ages 45–64
- Basic Benefit Package—Cost Impact of Recently Enacted Mandates

Sub-Populations: Uninsured Ages 45–64

Non-Elderly Arizonans			Arizonans Ages 45-64		
Total Population		4.5 m	Total Population		1.0 m (24%)
Geography:	Urban	77%	Geography:	Urban	74%
	Rural	23%		Rural	26%
Income:	< $25k	40%	Income:	< $25k	35%
	$25–50k	36%		$25–50k	34%
	> $50k	24%		> $50k	31%
Total Uninsured		1.2 m	Total Uninsured		205k (17%)
Uninsurance Rate		27%	Uninsurance Rate		19%

Basic Benefits Package—Mandated Benefits

Estimated Impact of Recently Enacted Health Insurance Mandates

	Mercer	CBO #1	CBO #2	AZ*
Continuity Care	0.3%	0.2%	0.2%	
Standing Referrals	0.1%	0.1%	0.1%	
Accessible DME	0.2%	N/A	N/A	
Prescription Drug	1.1%	N/A	<.05%	
Self-Referral Chiropractic	3.0%	N/A	N/A	
Access to Specialty	0.4%	0.1%	0.1%	
Emergency Services	0.4%	N/A	0.4%	
Cancer Clinical Trials	0.2%	0.1%	0.1%	

**Awaiting information from Health Insurance Industry*

Question and Answer

Statewide Health Care Insurance Plan Task Force

Arizona State Planning Grant:

Update from the Technical Advisory Committee

Steven P. Schramm, Principal
William M. Mercer, Incorporated

September 27, 2001

WILLIAM M. MERCER

Attachment V. C

Direction from the Task Force

Strategies for Technical Advisory Committee (TAC) to Review:

- Risk Pools
- Basic Benefit Package
- Purchasing Pools
- Health Care Group

Technical Advisory Committee's Approach

Use Guiding Principles to Review Task Force Issues and Develop Concrete Recommendations

- Basic Benefits
- Available and Accessible
- Affordable and Properly Financed
- Seamless System
- Stakeholder Collaboration to Foster Competition
- Public/Private Partnerships

Technical Advisory Committee's Approach

Strategies to Address Populations without Insurance (PWOI):

- Community-based Education on Value of Insurance
- Maximize Existing Federally-Supported Programs
- Develop Population-specific Solutions

Strategies to Keep Existing Insured Populations:

- To be Addressed in Future TAC/Task Force Meetings

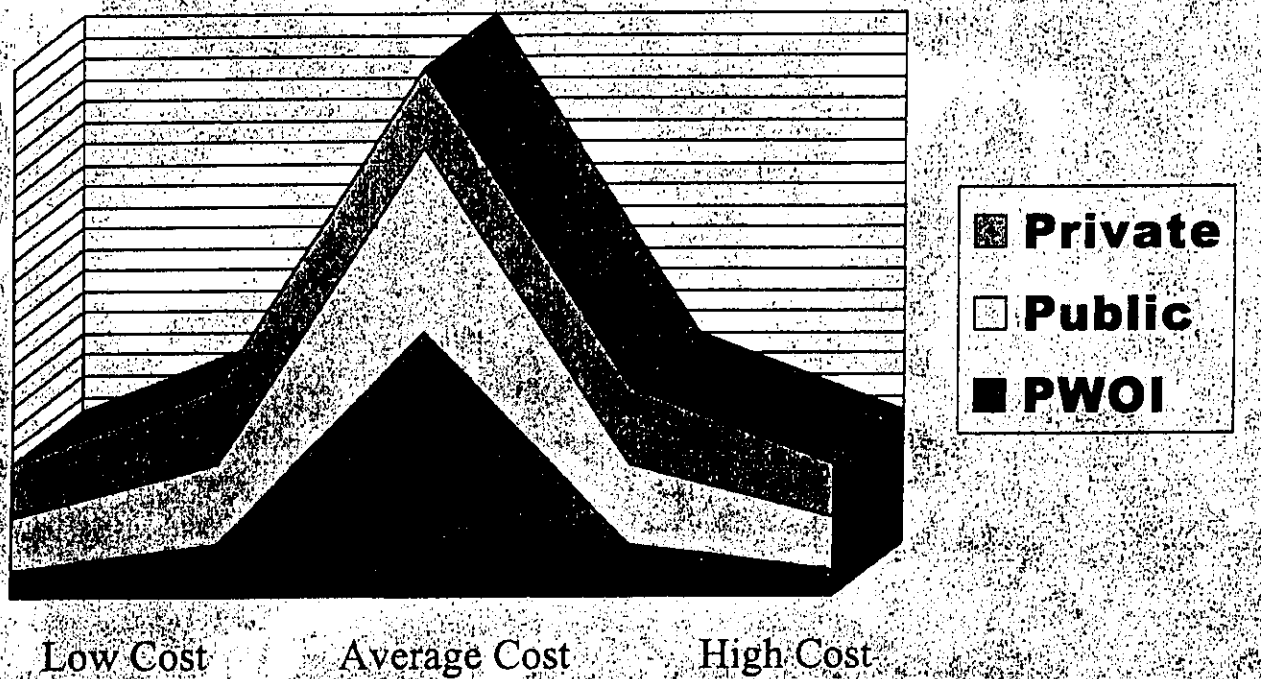
Technical Advisory Committee's Approach

Based on Guiding Principles, Develop Criteria for Success to Review Issues Forwarded by Task Force

Approach must:

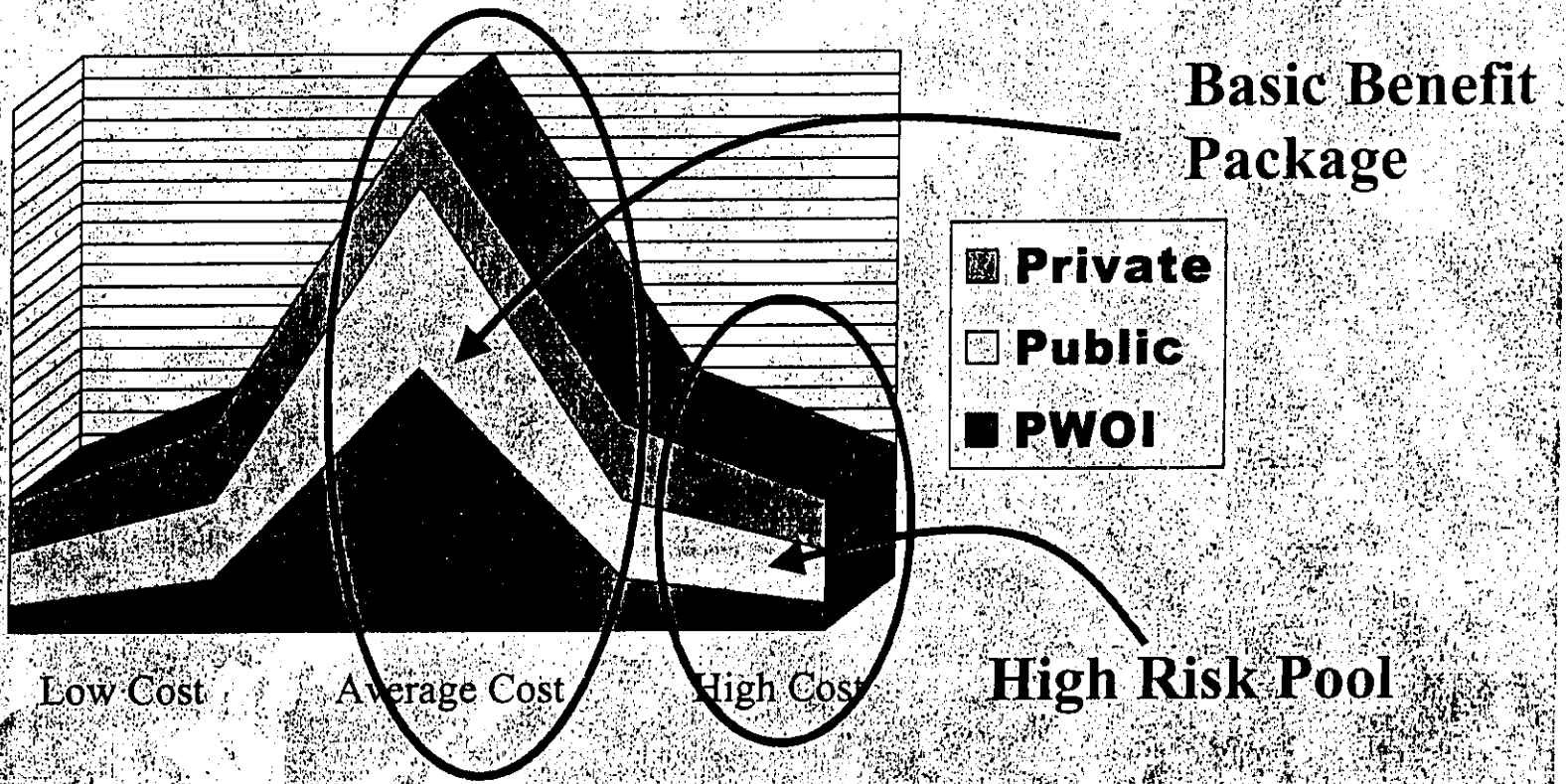
- Use available, affordable insurance vehicles to reduce the uninsured that would not be eligible for existing public programs
- Be an integrated solution targeted at specific populations and coordinate existing public and private programs

Technical Advisory Committee's Approach



Annual Health Care Costs Per Individual
Distribution of People

Technical Advisory Committee's Approach



Strategy: Risk Pools

Recommendation: Consider Establishing a High Risk Pool

- Target Population – High Cost/Uninsurable Individuals
- Benefits – Standard Market Benefits
- Service Delivery Network – Public/Private Partnership
- Funding – Multiple Sources (e.g., Public, Private, and Premium Funded)

Challenges:

- Funding – Identifying Appropriate Funding Mix

Critique of Proposed Basic Benefit Package

Key Focus for Arizona Policy Makers - Proposed Benefit Plan:

Arizona Basic Health Benefit Plan as a Starting Point

- *Not "Basic"*
- *Not Targeted at the Uninsured (or Working Insured - TAC)*
- *Not Affordable*
- *Not Attractive as Currently Available and Market Shows No Interest*

Strategy: Basic Benefit Package

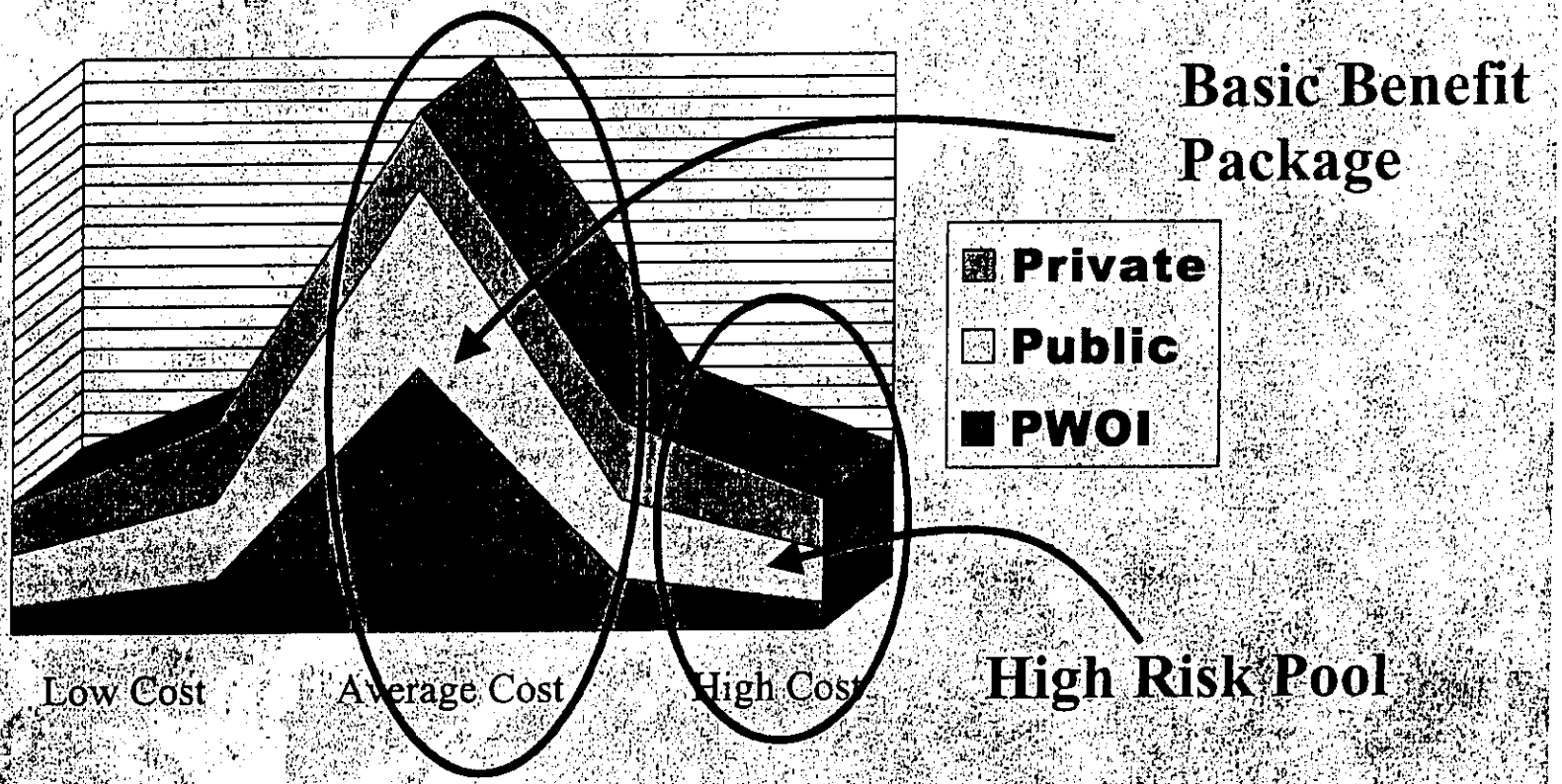
Recommendation: Allow True "Basic" Benefit Package

- Target Population – Working Insured and Uninsured
- Benefits – "Basic" Benefit Package (TBD) + Add-ons
- Service Delivery Network – Private Marketplace
- Funding – Self-Sustaining w/ High Risk Pool Coordination

Challenges:

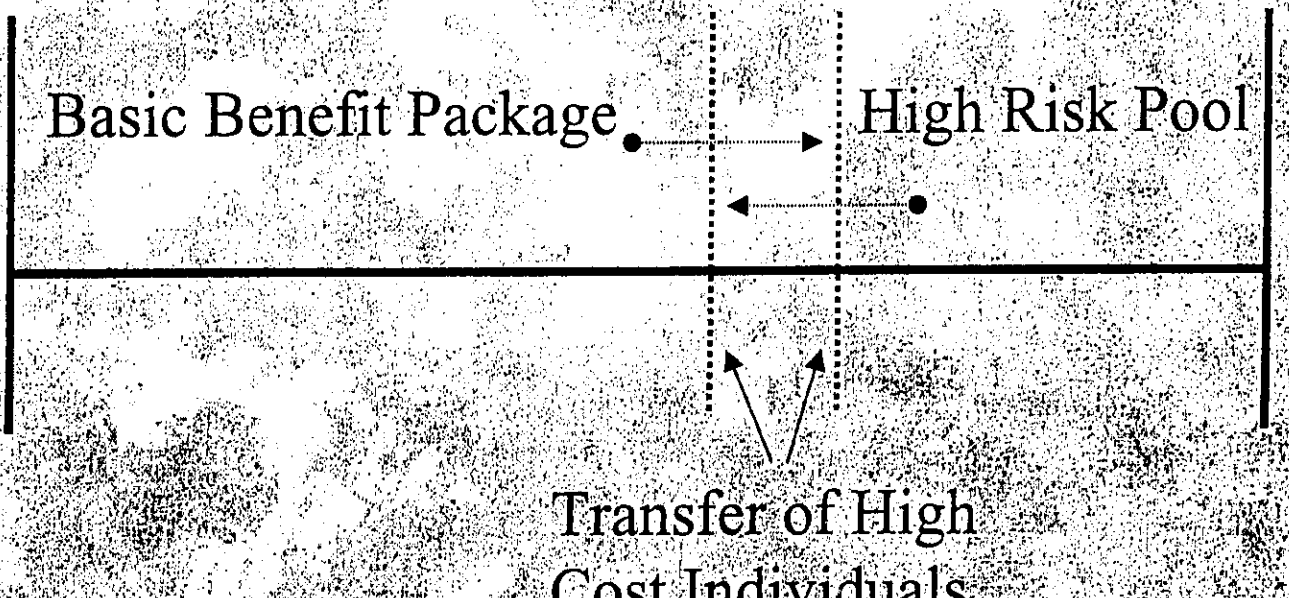
- Benefits – Department of Insurance Regulations on Minimum Benefits and Marketplace Development Time

Technical Advisory Committee's Approach



Annual Health Care Costs Per Individual
Distribution of People

High Risk Pool and Basic Benefit Interaction



Strategy: Purchasing Pools

Recommendation: No Change at this Time

- Legislation Already Exists for Purchasing Pools
- Affordability is Driven by the Benefit Package
- Need is for an Affordable Product

Strategy: Health Care Group (HCG)

Background:

- Small Employers – 1 to 50 Employees
- Currently Covers 12,000 Lives Statewide

Challenges:

- Uncertain Future – Adverse Selection, Enrollment Level
- No Permanent Funding Source for Subsidization

Bottom Line – Current Plans will NOT continue after June 2002 without Challenges Addressed

Strategy: Health Care Group

Key Current Features

- Limited to Small Employers and Political Subdivisions
- Not an Entitlement Program
- Members Pay Approx. 80% of Cost of Program
- Program Receives $6-$8 Million Annual Subsidy

Key Proposed Additions

- Hierarchical Eligibility
- Premium Structure that Varies by Household Income
- State to Assume Role of Administrative Clearinghouse
- Uniform Benefit Package

Strategy: Health Care Group

Recommendation: Retain HCG as a Transitional Vehicle until Task Force Proposals Implemented

- Proposed Changes Supported
- Questions Raised About
  - Subsidization by Income – Appropriate Level?
  - Benefit Package – Too Comprehensive?

Challenges:

- Proposed Changes Need Legislative Action by March 2002

Question and Answer

Statewide Health Care Insurance Plan Task Force

Arizona State Planning Grant:

Task Force Informational Requests

Steven P. Schramm and Michelle Taylor-Brklacich
William M. Mercer, Incorporated

November 14, 2001

WILLIAM M. MERCER

Attachment VI. A

Direction from the Task Force

Requested AHCCCS Provide Additional Information on:

- Health Insurance Administration Costs
- Elasticity of Demand for Health Care and Health Insurance
- Self-Insuring for Health Benefits

Health Insurance Administration Costs

- Typical Administrative Functions
  - Administrative Mgmt
  - Marketing
  - Claims Processing
  - Data Collection/Analysis
  - Actuarial Services
  - Network Development
  - Medical Mgmt
  - Case Mgmt

- Administrative Expenditures

Plan Type	*Admin Range*
Indemnity	12% to 18%
PPO	12% to 18%
POS	12% to 20%
HMO *	14% to 18%
HMO **	10% to 21%

* Commercial

** Medicaid

Elasticity of Demand for Health Care and Health Insurance

Elasticity = Change in Quantity divided by Change in Price

- Health Care Elasticity - Varies by Products v. Service .
- Health Care - Relatively Low Elasticity Varies by Service
  - Inpatient - Very Low Elasticity
  - Well-Care - Slightly More Elastic
- Health Insurance - Skews Elasticity as Insulates Price
  - As People have to Pay Higher % of Income for Premiums, Presentation Rates Drop

Self-Insuring for Health Benefits

Background

- Fully Insured - More Risk Averse Employers
  - Insurance Company Assumes Financial Risk
  - Insurance Company Maintains Reserves and Interest

- Self-Insured - Large Employers that can spread risk
  - Employer Assumes Financial Risk
  - Employer Maintains Reserves and Interest

- Minimum Premium - Mid Size Employers that like Stability
  - Insurance Company Determines amount of Employer Risk pt.
  - Employer Pays up to Risk, Insurer above that Risk

Self-Insuring for Health Benefits

Advantages

- Fully Insured
  - All Risk assumed by Insurance Company
  - Assets of Employer are protected against Legal Action
- Self-Insured
  - Employer Eliminates Insurance Profit and Risk Charges
  - Control of Plan Design and Flexibility stays w/ Employer
- Minimum Premium
  - Risk is Shared between Insurer and Employer up to Risk pt.
  - Employer Costs have Monthly Predictability

Self-Insuring for Health Benefits

Disadvantages

- Fully Insured
  - Insurance Company keeps Surpluses
  - Insurance Company controls Plan Design
- Self-Insured
  - Assets may be Exposed to Legal Liability due to Self-funded
  - Monthly Cash Flow can Fluctuate
- Minimum Premium
  - Legal Liability can Vary
  - Deficits carried Forward to be Recouped in Future Years

Question and Answer

Overview of Self-Insurance and State Employee Health Care Coverage

Statewide Healthcare Insurance Plan Taskforce

November 14, 2001

Gary Petersen
Consulting Actuary
Buck Consultants

BUCK CONSULTANTS

Attachment VI. B

Self-Insurance

- **Does Provide:**
  - An alternative way to finance the health benefits offered to employees
  - A way to save some fixed costs associated with purchasing insurance
  - A way to gain some control over plan design and administration
  - A way to broaden competition for state contract
  - A one time cash flow advantage in first budget year (i.e. cash accounting vs. accrual)

Self-Insurance

- **Does <u>Not</u>**
  - Provide any leverage in negotiating provider fees
  - Provide an automatic guarantee of lower claims
  - Suit those who can't tolerate significant budget variances at least once or twice every few years
  - Suit those unwilling to make tough decisions regarding "uncovered" services
  - Protect Employer from legal actions against plan

Self-Insurance

- **Plans controlled by ERISA (Employee Retirement Income Security Act of 1974)**
- **Subject to the Internal Revenue Service Code**
- **Oversight by the Department of Labor**
  - Annual Reporting on Plan Assets
  - Required Participant Communication
    - Summary Plan Description
    - Summary Annual Report
- **Exempt from State Insurance Laws (e.g. HB2600)**

Typical Insured Plan Rates

- Expected Claims (Historical + Index)
- Administrative Overhead and Risk Charges (10% - 21%)
- Commissions (0% on State)
- Premium Taxes (2%)
- Reserves - Possible (14% - 40%)

Self-Insurance
Typical Advantages

- **Plan Control**
  - Managed Care Concepts
    - Network Management, Pre-certification/Referral, etc.
- **Plan Design**
  - Benefit Level Design
    - Eligibility, Deductibles, Coinsurance, Copays, etc.
- **Cost Savings**
  - Insurance Company Retention
    - Overhead Expenses, Risk Charges, Premium Taxes, Interest on Reserves, Profit Margin

Self-Insurance

Pricing as an Art...

- Employer assumes risk for health care expenses provided to employees
- Target premium set aside in Trust fund to pay eligible plan expenses
- Target premium determined
  - historical claims
  - trend and margin for claims fluctuation
  - reinsurance costs
  - contract administrator fees
  - other administrative plan expenses

Self-Insurance Variations

- **100% Self-Insured**
  - Employer guarantees all assets, if necessary, to pay plan expenses.
- **Stop Loss Coverage**
  - Specific
    - Coverage threshold on a per participant basis (typical coverage on large employer $350,000 +)
  - Aggregate
    - coverage threshold on a total group basis (unlikely to get "competitive" quote on State)

Self-Insurance
State Review

- **Hired Buck Consultants to identify process and risks associated with moving plans to self-insurance.**

  Issues under review:
  - Ability, if any, to leverage AHCCCS capabilities
  - Ability to deal with budget variations
  - Outline functional responsibilities under self-insurance
  - RFP for components of Self-Insured Plan

BUCK CONSULTANTS

Self-Insurance Continuum

- **Highest likelihood of Financial Success**
  - Statewide PPO (Year 2 increase up to 30%)
  - Prescription Drug carve-out (all products?)
- **Least likelihood of Financial Success**
  - Urban HMO (Year 2 increase 15-18% max)

DRAFT – For Discussion Purposes Only

State Health Care Insurance Plan Task Force: Statement of Legislative Intent

Purpose:

The State Health Care Insurance Plan Task Force has indicated that one of its desired outcomes is the introduction of legislation in the 2002 session that will serve as a statement of legislative intent. This statement of legislative intent would begin to describe the type of seamless health care system that the Task Force and Legislature would like to see in place in Arizona. The statement would outline characteristics of such a seamless system; identifying strategies which could be implemented over the next three (3) to four (4) years to enhance the development of such a system

Preliminary Statement of Legislative Intent

Based on the presentations and debate at previous Task Force meetings, the following forms a beginning framework for such a statement of legislative intent:

Guiding Principles

Over the next three (3) to four (4) years, the Legislature is committed to building a health care system in Arizona which will support and promote the following five (5) guiding principles:

- Health care should be available and accessible; especially basic benefits
- Health care should be affordable and properly financed
- Health care should be provided through a seamless system
- Health care should be done in collaboration and in cooperation with the various stakeholders both public and private sectors and it should foster competition
- Public private partnerships should be sought

To this end, the Legislature has identified below goal statements which will allow the State to transform the current health care system into one that offers affordable, accessible health care coverage including coverage choice to all Arizonans.

Goal Statements

- Work to assure that insured persons in the system stay insured; minimizing any unintended consequences from changes to the system that would lead to a reduction in persons covered through the private marketplace.

- Maximize the enrollment of uninsured individuals in existing income and non-income based public supported programs for which they are eligible.

- Agree to timing and approach for expansion of current Title XIX/XXI eligibility criteria (e.g., increasing income levels for various eligibility groups) for selected populations.

- Restructure the current state employee and retirement health care coverage program; evaluating the merits of moving to a self-insured system and developing strategies that would expand the size of the pool and promote greater choice of coverage options.

- Narrow the gap between existing public and private health coverage programs through carefully researched and tested interventions including but not limited to:

    1. Make changes to basic benefits definitions and offerings;

    2. Construct and fund an actuarially sound high risk pool (continue to study the relative risks and rewards associated with purchasing pool type models);

    3. Mandate participation in disease management programs;

    4. Invigorate efforts to improve the marketing and sales of state sponsored or other privately supported health coverage programs, including marketing programs on the value of health care coverage and modifications to state insurance regulations; and

    5. Support transitional programs and/or strategies that bridge the gap between 100% publicly supported coverage and the private marketplace.

- Coordinate existing rural health care resources and programs that support and enhance the rural health care infra-structure.

Access to Primary Care -
A Community Health Center Plan for Arizona (2002 - 2006)

Mary M. Mauldin
Director of Community Development
Arizona Association of Community Health Centers
November 26, 2001

The Challenge

- How do we in the State of Arizona assure that our residents have access to Primary Health Care?

Access to Primary Care

- Requires Health Insurance and

MORE!

Access Involves:

- Facilities/ Clinics within a reasonable driving distance
- Sufficient Providers in the community
- Financial means to pay for care
  - Insurance and affordable co-pay/deductibles
  - Self-pay under a sliding fee scale program

Access Means:

- Patients can get an appointment within a reasonable time period
- Patients can get to a provider who is within a reasonable distance (30 miles or 30 minutes or less)
- Patients can receive care from Providers who are able to communicate with them and understand their circumstances

- Clinics can afford the upkeep, rent increases, overhead to stay open
- Clinics can afford the equipment and supplies needed to provide services
- Providers can "make a living" in the community and are committed to staying

What is a Community Health Center (CHC)?

- Non-profit primary care centers that serve everyone in the community – low-income uninsured pay on a sliding fee scale.
- Functions like an ER. Must see everyone who presents for care.
- In designated medically underserved and rural communities
- Run by a Community Board of Directors made up of at least 51% users of the clinic
- Primary care services include internal medicine, OB/GYN, Pediatrics, Family Practice
- Additional services provided at CHCs include dental, behavioral health, pharmacy, transportation, outreach and enrollment and preceptorships
- **Arizona has 34 CHCs with 85 locations around Arizona.**
- Patient payor mix is ~32% uninsured, 34% AHCCCS, 22% private insurance, 6% Medicare

How are Community Health Centers Important to Arizona's Healthcare Delivery System?

- Community Health Centers are the system's safety-net providers – "catching" those who are seen nowhere else.
- AACHC members see approximately 25% of the total AHCCCS population
- Over 20 communities would have no AHCCCS provider without the local Community Health Center
- Some of those communities would have NO PROVIDER at all without the local Community Health Center
- CHCs help alleviate hospital room overcrowding
- Recruit and help retain providers in the rural and underserved areas
- Innovative uses of technology – telemedicine, on-line applications, common integrated service network

In conducting our statewide strategic planning process with our member Primary Care clinics

- We explored those factors that define accessible Primary Health Care and asked the following questions:

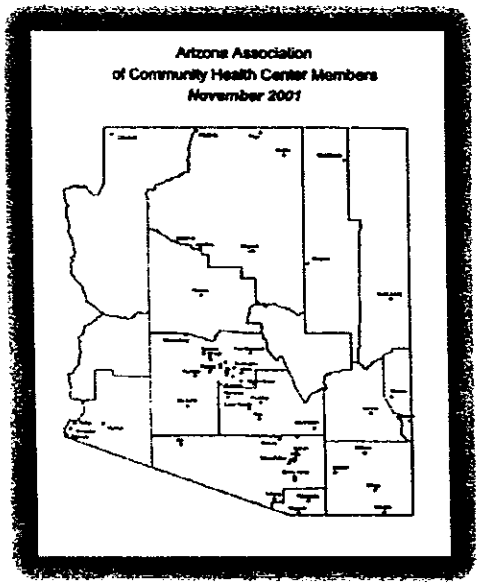
How do we assure that adequate **facilities** delivering primary care are available?

How do we assure that the necessary **workforce** is available?

How do we assure that the necessary **financial resources** to pay for health care services is available?

Access to Health Care in Arizona: Existing Coverage and Access Gaps

Map of current member Primary Care Clinics and satellites (Map A)

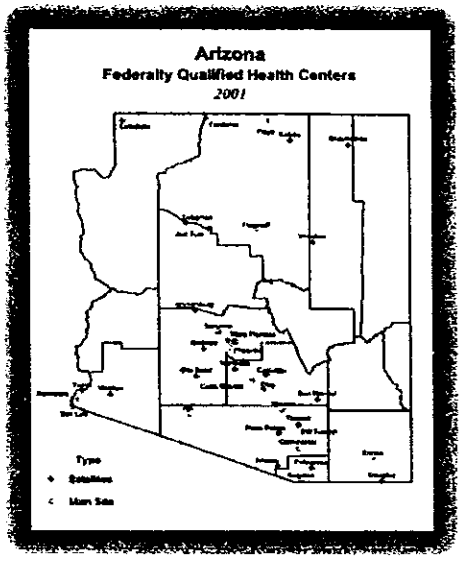


Map A

Planned Growth—New Sites

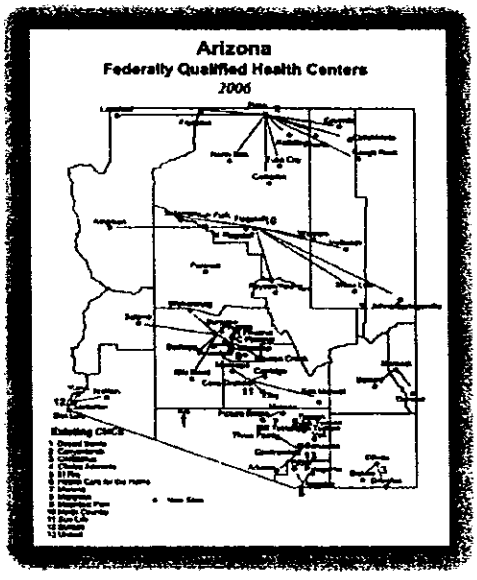
- Primary Care access for more patients

Map of Existing CHCs and Satellite Clinics (Map B)



Map B

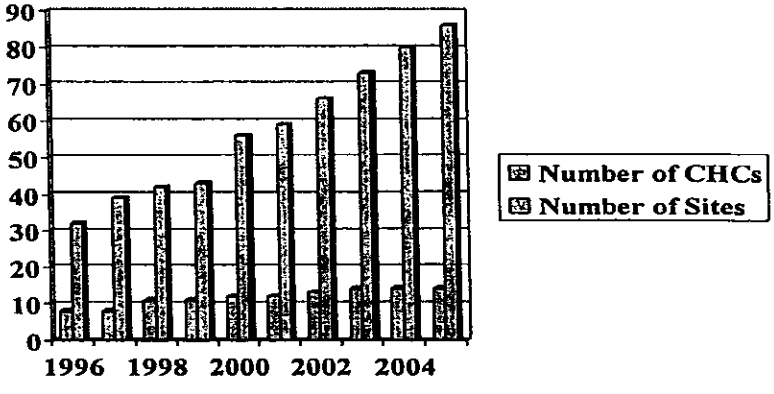
Map of Projected CHCs and Satellite Clinics (Map C)



Map C

2006

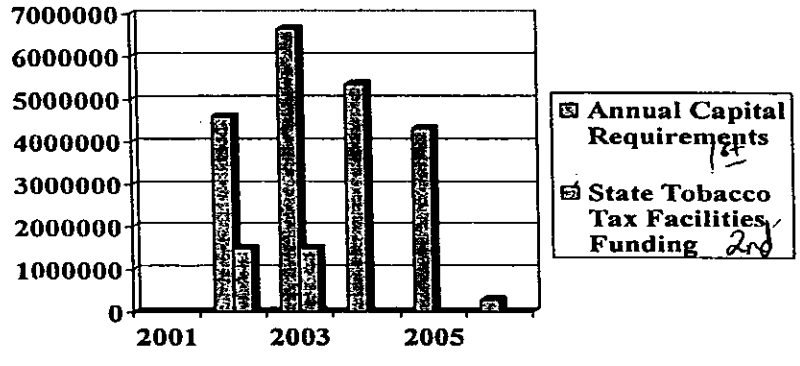
Actual and Projected CHCs and New Sites



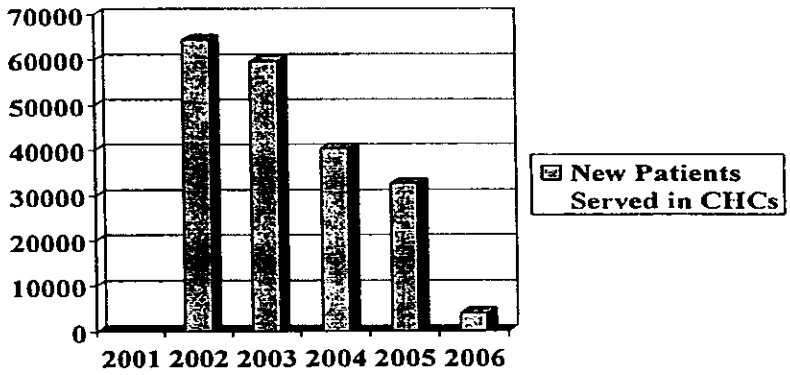
Dollars Needed to Support Sites for Increased Primary Care Access

- Capital funds
- Funds/ resources for health care coverage for the uninsured

Additional Capital Dollars Needed– Actual and Projected

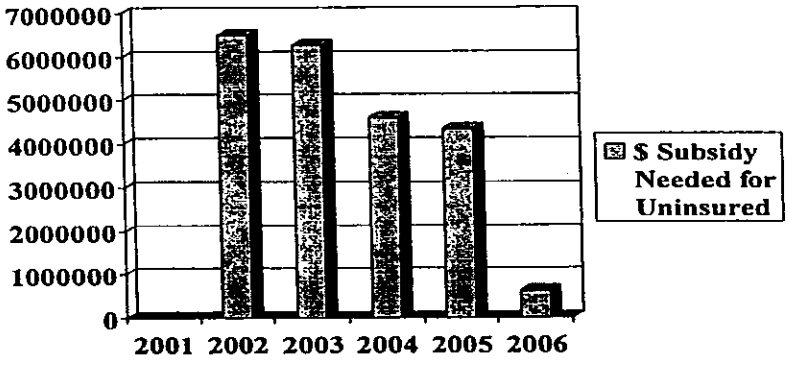


New Patients Added to Clinic Rolls - Projected



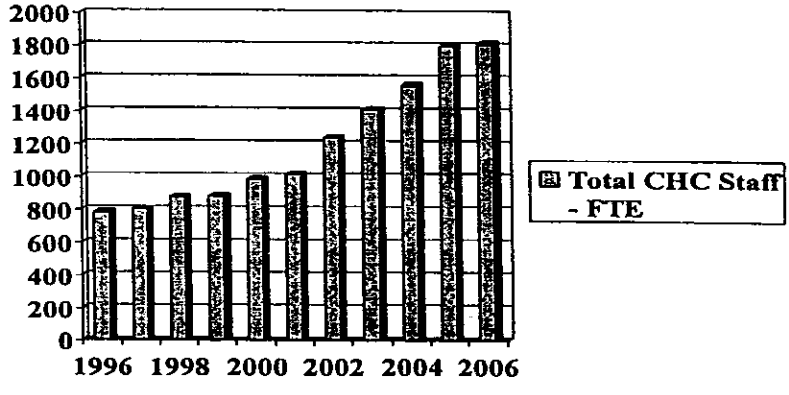
$N_{06} \simeq 175,680$

Additional Financial Resources Needed for "Uninsured"

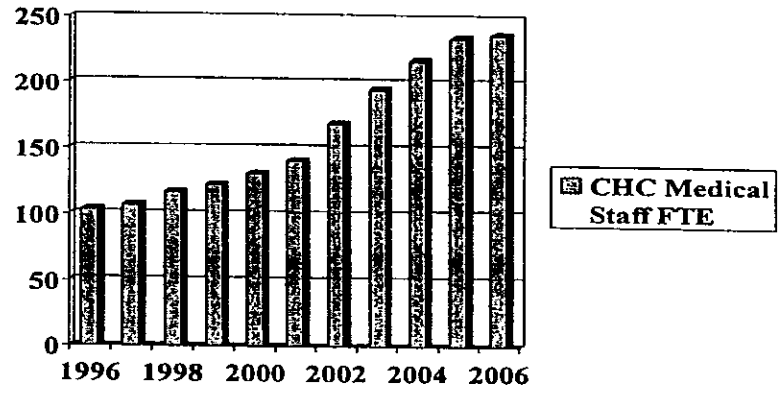


Workforce Needed to Achieve Increased Access to Primary Care Services

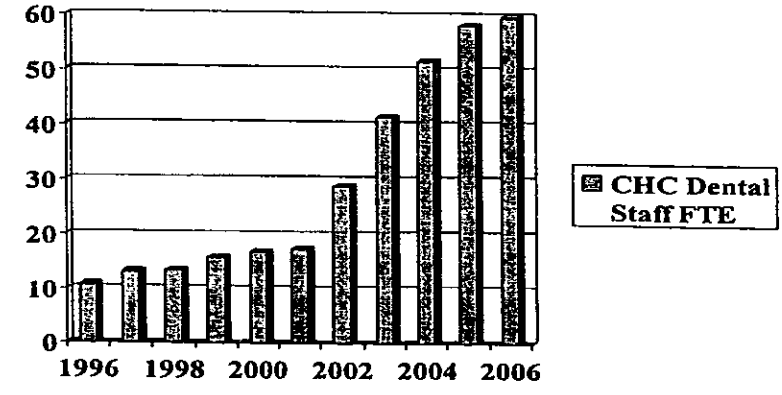
Total Numbers of All CHC Staff – Actual and Projected



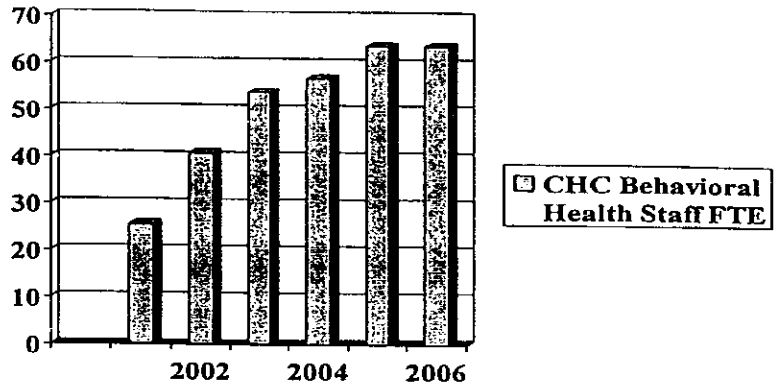
Actual and Projected CHC Medical Providers



Actual and Projected CHC Dental Providers



Actual and Projected CHC Behavioral Health Providers



Profile of the CHC of the Future

- Provides comprehensive primary **medical** care
- Provides primary **dental** care
- Provides Integrated **Behavioral Health** care in conjunction with primary care

This profile is realizable within the next five years

- Today most CHCs have onsite dental care
- Most CHCs have onsite mental health care
- Four CHCs have begun Integrated Behavioral Health care

Recent results of new and expanded access in Arizona

- FY2001 new site expansions
  - Winslow by North Country CHC
  - Douglas by Chiricahua CHC
  - West Phoenix by Mountain Park HC
- FY2001 service expansions
  - Behavioral Health – four CHCs
    - El Rio, Marana, Mountain Park, North Country
  - Pharmacy – Chiricahua CHC

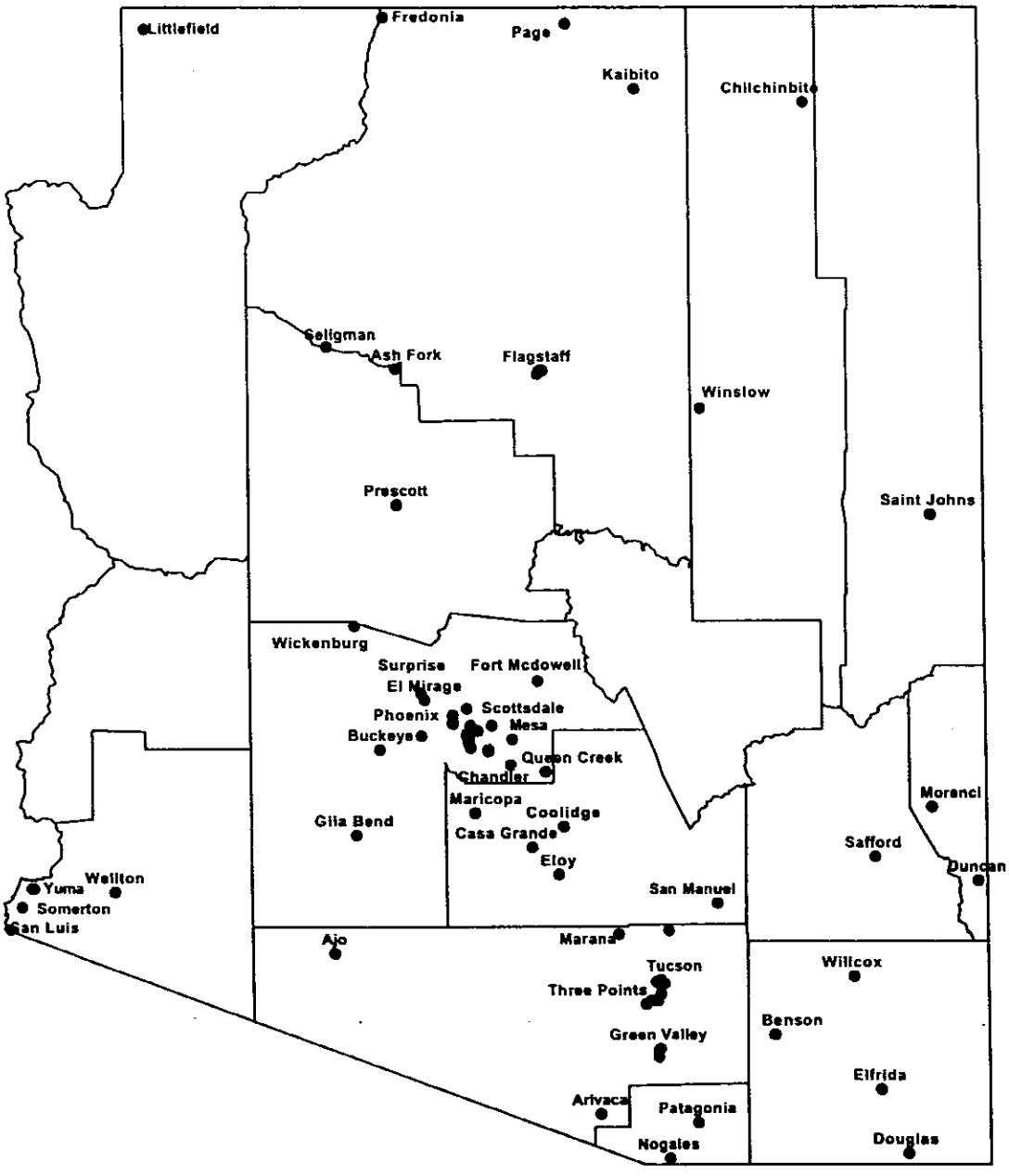
Implications of limited or no access to primary care

- Patients will eventually seek and receive care at an emergency facility
  - The most expensive means to addressing the problem
  - The most inappropriate site for primary care
  - And entailing far greater pain and suffering for the patient

In summary, AACHC developed

- A Five-year Plan to increase Primary Care access in Arizona.
- A road map to focus Community Development efforts.
- The first step in a multi-step planning process to systematically project resources needed to accomplish the goal of increased access.
- The plan to be followed by business plan development, capital fund raising, and workforce development in partnership with other interested and committed parties.

Arizona Association
of Community Health Center Members
November 2001

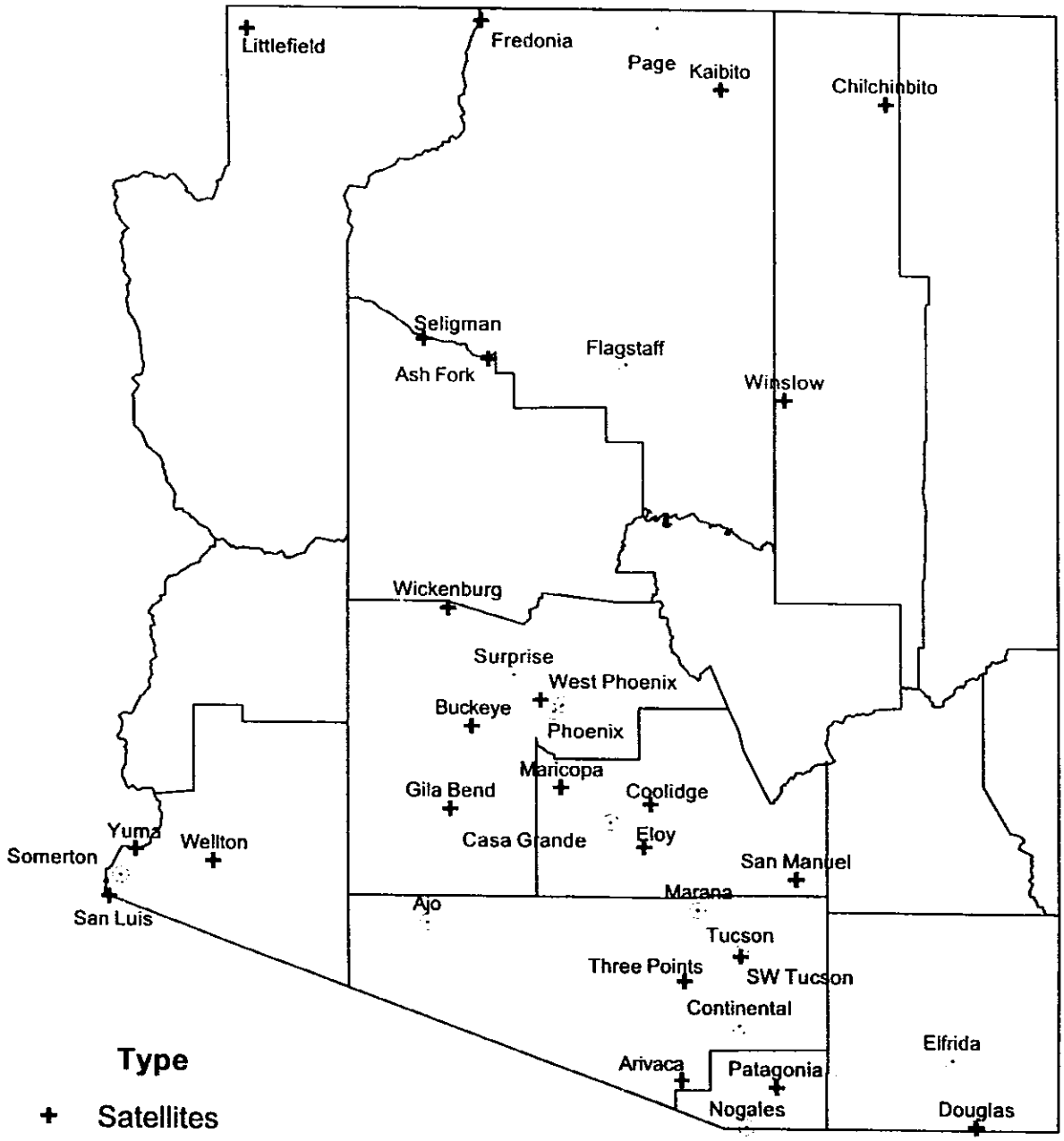


Map A

Arizona

Federally Qualified Health Centers

2001

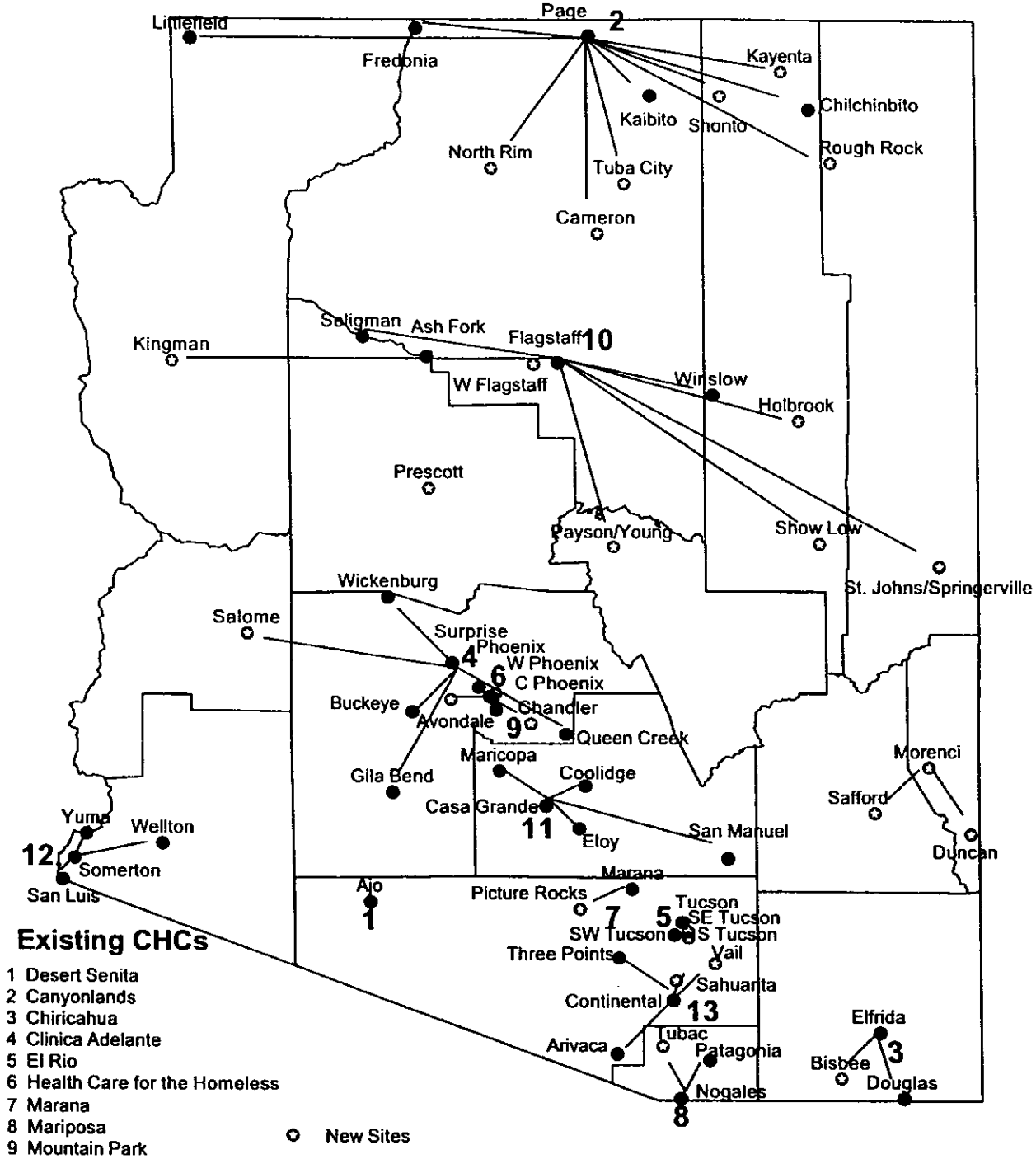


Map B

Arizona

Federally Qualified Health Centers

2006



Existing CHCs

1 Desert Senita
2 Canyonlands
3 Chiricahua
4 Clinica Adelante
5 El Rio
6 Health Care for the Homeless
7 Marana
8 Mariposa
9 Mountain Park
10 North Country
11 Sun Life
12 Sunset
13 United

Map C

Recommendations to Statewide Health Insurance Task Force

Continue to fund the Primary Care Programs

The "Qualifying Community Health Center Program" is currently funded out of the tobacco tax account at $6 million. It was cut by $3 million this fiscal year and is scheduled for another $1.25 million cut next fiscal year. We must continue this program at least at the $6 million level so the safety-net providers may continue to provide services to those that no other system will.

Continue to fund Clinic Construction Program

The state has provided competitive grant funds for primary care clinics in rural and underserved areas to build, renovate or expand their facilities in order to provide more services to the uninsured. There is a match required by the community to receive the funds, and at least 50% of the funding must go to a rural area. This program has been extremely successful with $1.5 - $2.5 million funding in each of the last four years. 19 communities have updated or newly built clinics for their constituents.

Increase funding to the State Loan Provider Program

This program receives a 1 to 1 match from the federal government to providers who practice in a designated "Health Professional Shortage Area" (HPSA). The program pays a set amount of a provider's student loans for the time he/she practices in the HPSA. This program is an excellent recruitment and retention tool for rural communities.

The program only receives $100,000 and has never been increased since its inception in 1995.

Statewide Health Care Insurance Plan Taskforce Meeting
Assessment of Arizona Health Care Coverage

Howard J. Eng, Dr. P.H.

Southwest Border Rural Health Research Center
Rural Health Office
College of Public Health
University of Arizona
Tucson, Arizona

November 26, 2001

Assessment Commissioned by AHCCCS Funded by HRSA State Planning Grant

Assessment Team

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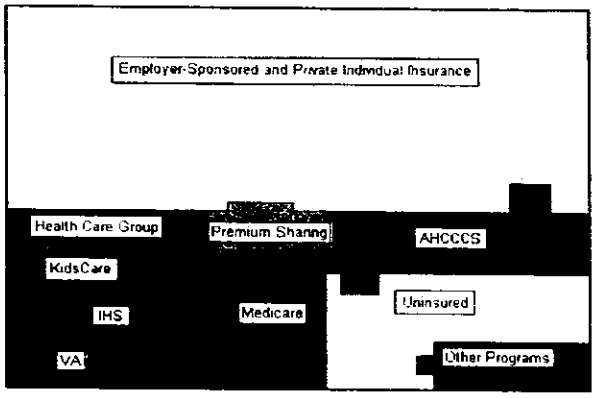
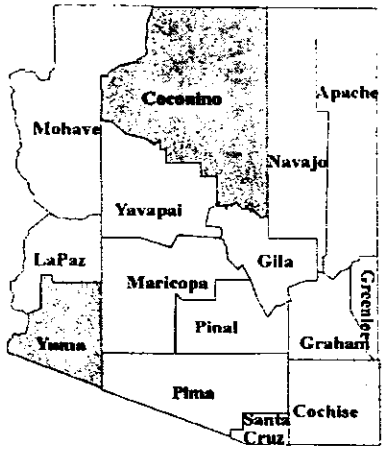
Consultants

Merlin DuVal
Karl Yordy
Ronald Vogel
Joel Brill

Putting Together the Arizona Health Care Puzzle



Arizona's 15 Counties

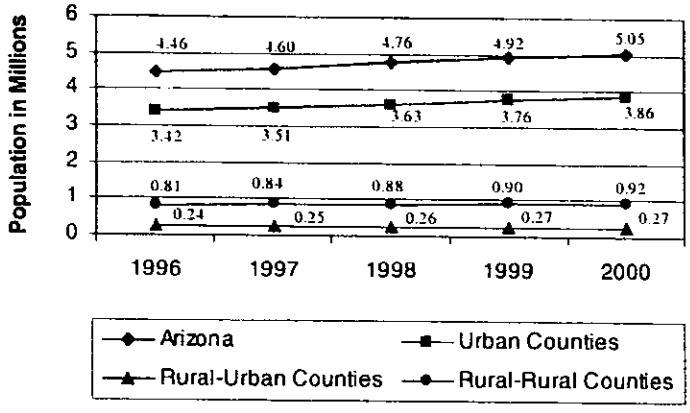


Urban (U) Counties (at least one community with a population of 500,000 or greater)

Rural-Urban (RU) Counties (at least one community with a population of 50,000 or greater)

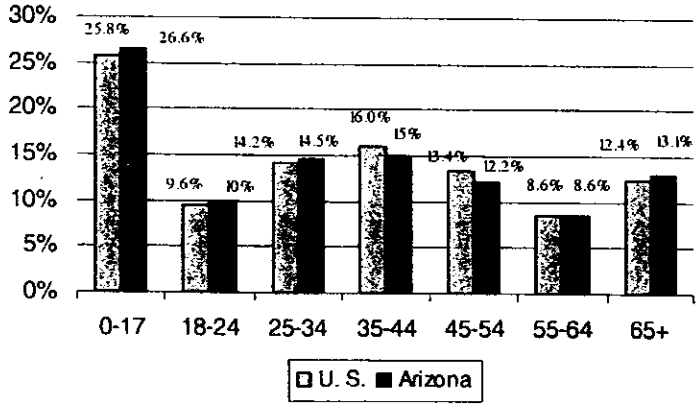
Rural-Rural (RR) Counties (all communities have a population of less than 50,000)

Arizona State and County Population Trend Estimates: 1996-2000



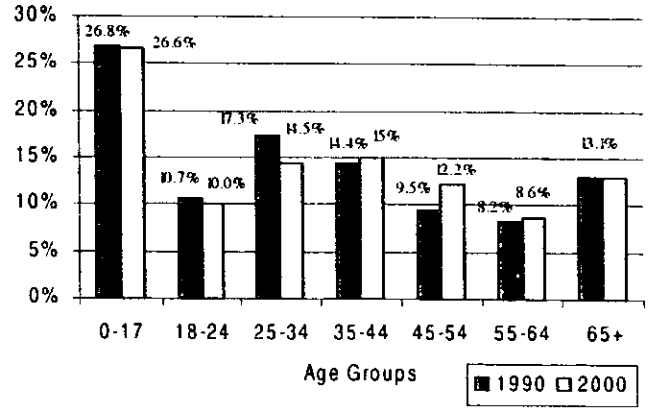
Source: Arizona Department of Economic Security (DES) Research Administration, Population Statistical Unit, Resident Estimates as of July 1, 1996-2000

Percentage Comparison of Age Group Distribution: United States and Arizona



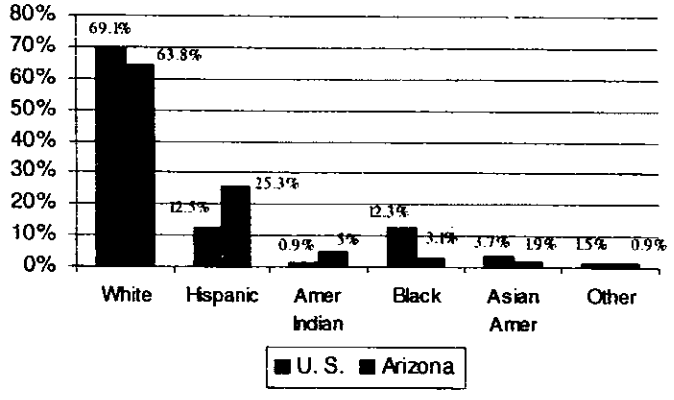
Source: U. S. Census 2000

Percentage Comparison of Arizona Age Group Distribution: 1990 and 2000



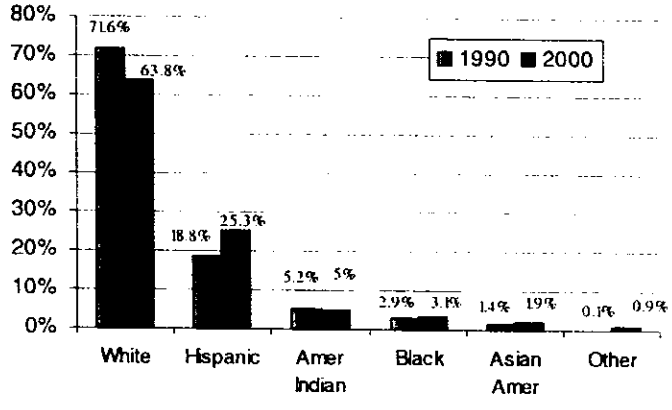
Source: U. S. Census 1990 and 2000

Percentage Comparison of Race/Ethnicity Distribution: United States and Arizona



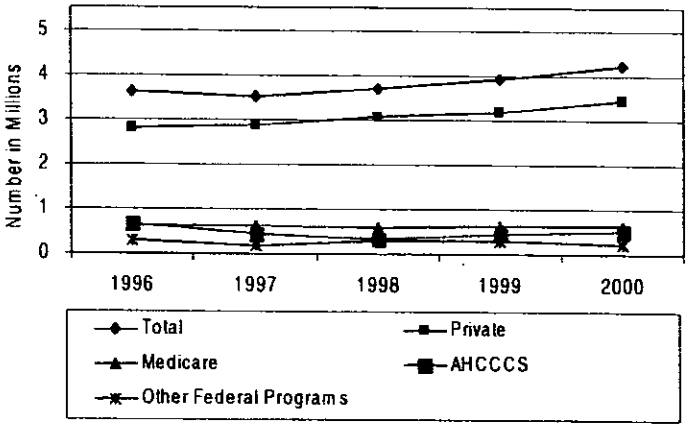
Source: U. S. Census 2000

Percentage Comparison of Arizona Race/Ethnicity Distribution: 1990 and 2000



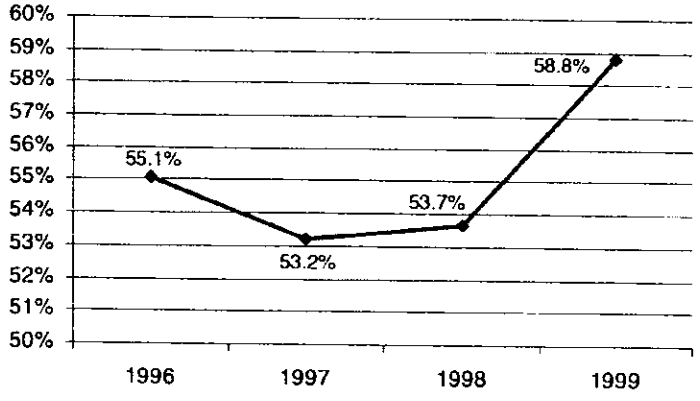
Source: U. S. Census 1990 and 2000

Arizona Selected Health Care Coverage Programs: 1996-2000 Estimates*



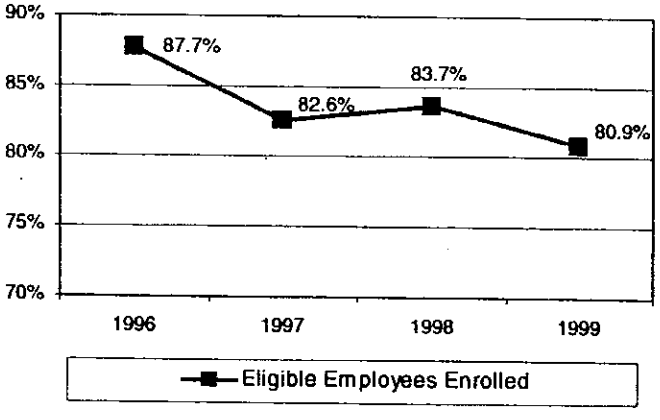
Source: U. S. Census Bureau: Health Insurance Historical Table 4
*U.S. Census revised figures for 1999 and 2000

Percent of Arizona Private-Sector Establishments that Offer Health Insurance to Employees: 1996-1999 Estimates



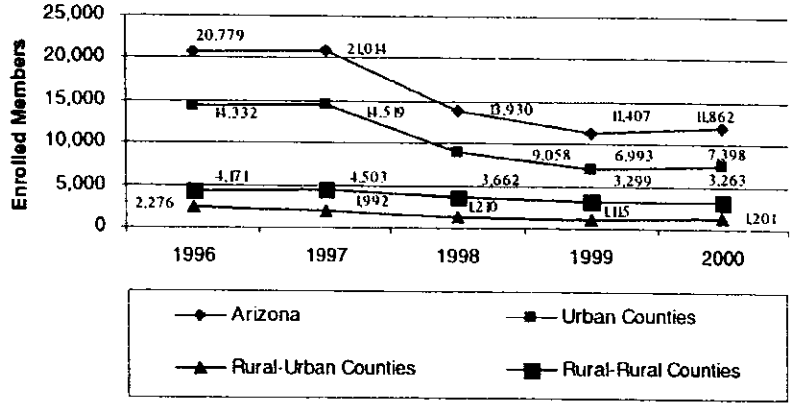
Source: AHRQ, 1996-1999 Medical Expenditure Panel Survey (MEPS) - Insurance Component

Percentage of Arizona Private-Sector Employees Enrolled in Employer-Sponsored Insurance: 1996-1999 Estimates



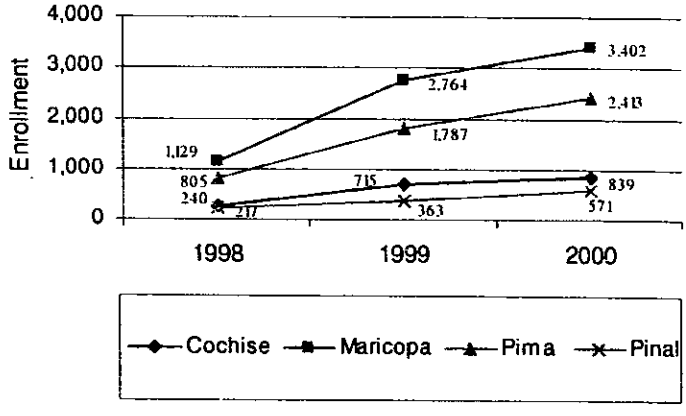
Source: AHRQ, 1996-1999 Medical Expenditure Panel Survey (MEPS) - Insurance Component

Arizona State and County Health Care Group Enrollment: 1996-2000



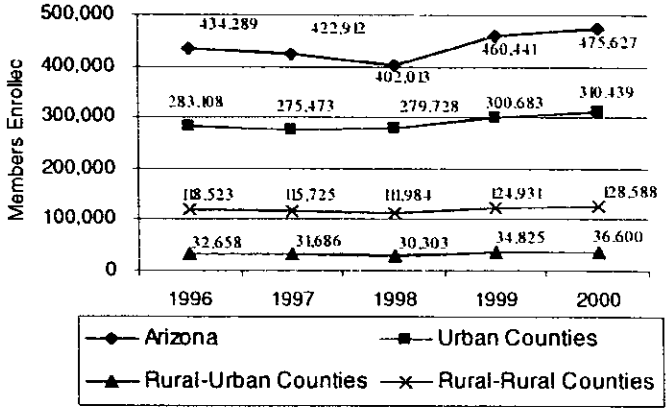
Source: AHCCCS, Division of Member Services

Arizona County Premium Sharing Enrollment: 1998-2000



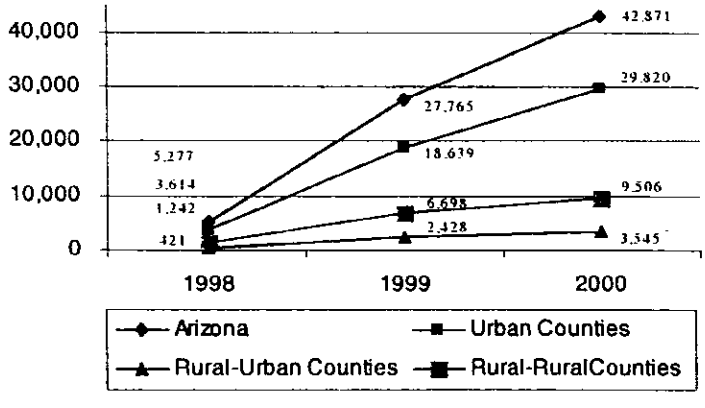
Source: AHCCCS, Division of Member Services

Arizona State and County AHCCCS (Medicaid) Enrollment: 1996-2000



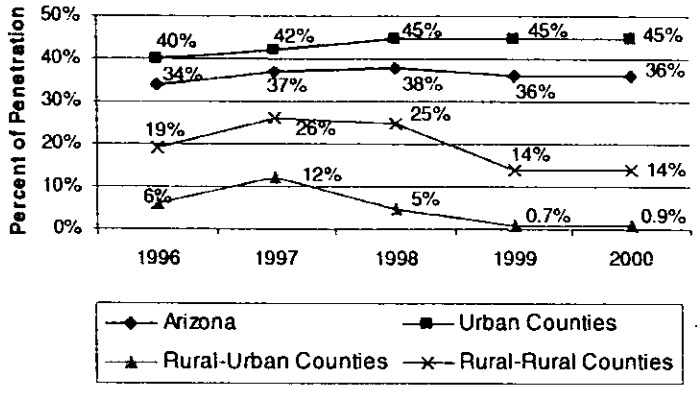
Source: AHCCCS, Division of Member Services
Note: All figures as of December 1st of each year

Arizona State and County KidsCare (SCHIP) Enrollment: 1998-2000



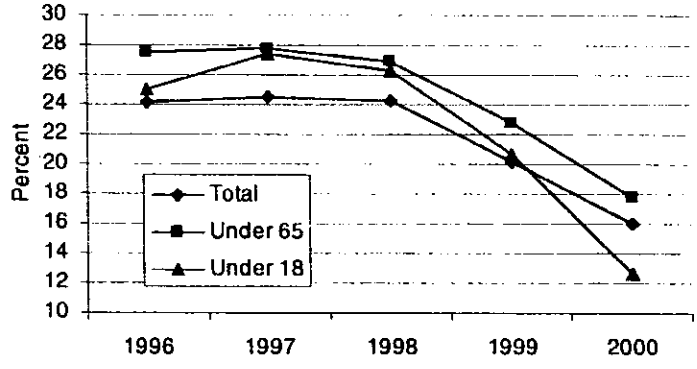
Source: AHCCCS, Division of Member Services
Note: All figures as of December 31st of each year

Percent of Arizona State and County Medicare HMO Enrollment Penetration: 1996-2000

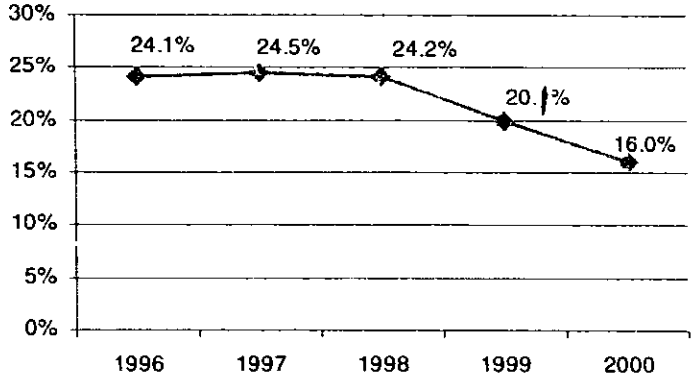


Source: HCFA, Medicare Managed Care Penetration by State and County, December 31, 1996-2000 and June 30,2000

Arizona's Three CPS Uninsured Rates

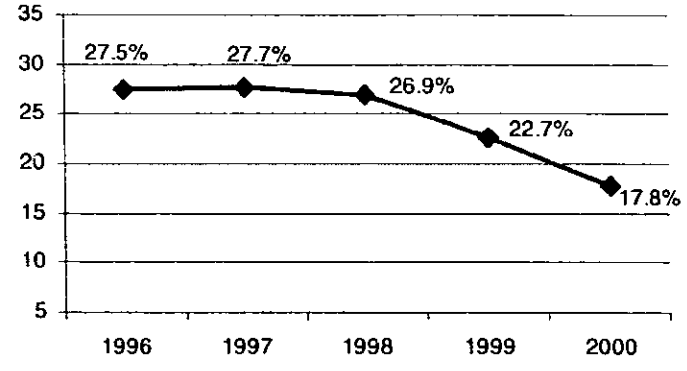


Arizona Uninsured Population Estimates: 1996-2000*



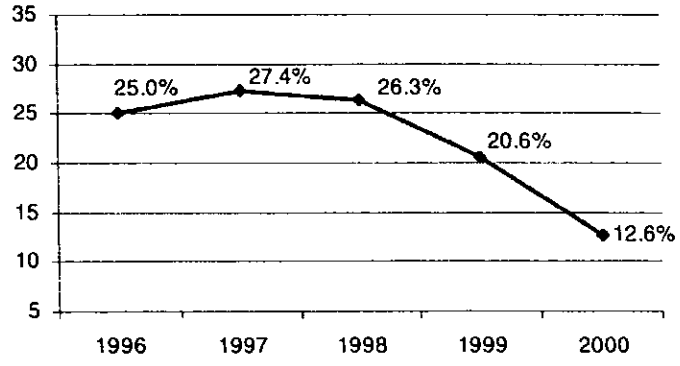
Source: U. S. Census Bureau: Health Insurance Historical Table 6
*U.S. Census revised figures for 1999 and 2000

Arizona Uninsured Under 65 Population Estimates: 1996-2000*



Source: U. S. Census Bureau: Health Insurance Historical Table 4
*U.S. Census revised figures for 1999 and 2000

Arizona Uninsured Under 18 Population Estimates: 1996-2000*



Source: U. S. Census Bureau: Health Insurance Historical Table 5
*U.S. Census revised figures for 1999 and 2000

Characteristics of Arizona Uninsured

- Male 18-25 years > Other Male Age Groups
- Young Males > Young Females
- Minorities > Whites
- Hispanics > Other Minorities
- Lower Income > Higher Income
- Unemployed > Employed
- Part-time Employees > Full-time Employees
- Small Firm Employees > Large Firm Employees
- Rural Residents > Urban Residents

Statewide Health Care Insurance Plan Task Force

Arizona State Planning Grant: Task Force Informational Request

Michelle Taylor-Brklacich and Steven P. Schramm

December 11, 2001

WILLIAM M. MERCER

Attachment VIII. A

Direction from the Task Force

Requested AHCCCS Provide Additional Information on:

Questions

- Which states self-fund?
- Can additional populations participate?
- Do any states perform their own plan administration?
- What are the levels of risk tolerance?
- Are any of the self-funding programs part of larger statewide health insurance reform initiatives?

Direction from the Task Force

Requested AHCCCS Provide Additional Information on:

Barriers

- What are the legal barriers, (e.g., ERISA) to allowing small groups to join public purchasing pools, METs and/or MEWAs?
- Are there barriers to allowing full-cost buy-in to these self-funded arrangements or public purchasing pools?

Self-Funding Survey

Methodology:

- Telephonic survey of all 50 states
- Responses received from all 50 states

Results:

- 34 (68.0%) of the 50 states responding self-fund at least one of their medical plans
- Of the 16 states that do not currently self-fund, five are considering self-funding

Self-Funding Survey Results

Of the 34 states that self-fund:

- 13 (38.2%) self-fund all of the medical plans
- 21 (61.8%) fully-insure their HMOs while self-funding Indemnity, PPO, EPO and/or POS plans
- Only 5 (15.2%) offer self-funded Indemnity plans
- The length of time that the states have offered self-funded plans varies from 35 years to 1 year with the average duration of 15 years
- None of the states include the self-funded employee plan as part of larger statewide health insurance reform or expansion initiatives

Self-Funding Survey Results

Of the 34 states that self-fund:

- 25 (73.5%) currently allow other groups to participate. The other groups vary, but include:
  - Counties, cities, towns, municipalities, principalities, irrigation/water districts and political subdivisions
  - Universities, community colleges, school districts and libraries
  - State agencies
- Of the 9 states that do not allow other groups to participate, 5 are considering changing this policy

Self-Funding Survey Results

Of the 34 states that self-fund:

- All 34 contract with outside vendors to provide some administrative services
- One state performs its own claims administration
- All 34 states contract with outside vendors for utilization review/management services
- Four states contract directly with pharmacy benefit management firms
- Only 3 states (6.0%) purchase stop loss coverage, and both states only purchase "specific" coverage (i.e., coverage based on individual claimant totals)

METs, MEWAs and Purchasing Pools

Multiple Employer Welfare Arrangements (MEWAs) and Multiple Employer Trusts (METs)

- ***Definition*** - employee benefit plans established for the purpose of offering defined employee benefits to the employees of two or more employers (including one or more self-employed individuals)
- METs were the early incarnation of MEWAs
- MEWAs and METs are formal entities
- MEWAs can be regulated by states as an insurer and by the Department of Labor regarding ERISA compliance.
- State regulation of MEWAs is inconsistent

METs, MEWAs and Purchasing Pools

Multiple Employer Welfare Arrangements (MEWAs) and Multiple Employer Trusts (METs)

- Appeal to small businesses as a vehicle to provide affordable health insurance
- Can offer fully-insured or self-funded coverage
- Not fully-insured MEWAs likely to be subject to state certification
- Governmental employers generally can purchase jointly through Inter Governmental Agreements (IGAs) with no need to form a MEWA or MET

Health Care Group

Key Current Features

- Limited to Small Employers and Political Subdivisions
- Not an Entitlement Program
- Members Pay Approx 80% of Cost of Program
- Program Receives $6-$8 Million Annual Subsidy

Key Proposed Additions

- Hierarchical Eligibility
- Premium Structure that Varies by Household Income
- State to Assume Role of Administrative Clearinghouse
- Uniform Benefit Package

Question and Answer

Summary of Health Care Group Program

DRAFT

Current Programs versus Proposed Program

	Current HCG	*Proposed HCG*
Program Design	▪ Not an entitlement program ▪ Voluntary participation from employers ▪ Funding from State General Funds ▪ Members pay for approximately 80% of cost ▪ HCG and Plans split administrative duties ▪ HCG administration funded solely out of premiums	▪ *All Current HCG PLUS* ▪ Hierarchical eligibility using universal application ▪ Means-testing to maximize effectiveness of subsidy and vary by income ▪ Premium based on employee's household income and age ▪ State to assume major administrative duties requiring addt'l funding & resources
Target Population	▪ Employees and dependents working for employers with 1 to 50 employees ▪ Political subdivisions ▪ Eligible employees are those working ≥ 32 hrs/wk ▪ Participation requirements - 1 to 5 employees 100% - 6 to 50 employees 80%	▪ *All Current HCG PLUS* ▪ Expand eligible employees to those working ≥ 20 hrs/wk
Benefit	Covered: ▪ Services varied by plan ▪ Copays are closer to that of a commercial population - Inpatient $100 - ER $50 - Physician $10 - RX $5 ▪ Well-person care @ standard co-pays ▪ Lifetime max $2m Excluded: ▪ Transplants ▪ SNF ▪ BH ▪ NEMT	Covered: ▪ Standardized across plans ▪ Copays are closer to that of a commercial population - Inpatient $100 - ER $100 - Physician $20 - RX at $15/$30 for generic/brand ▪ Well-person care @ reduced copays $10 ▪ Lifetime max $2m Excluded ▪ Transplants ▪ SNF ▪ BH ▪ NEMT
Service Delivery Network	▪ Medicaid health plans ▪ Statutorily could be any health plan	▪ *All Current Plus* ▪ Oct 2001 – UPI and Mercy will cover 11 counties

Statewide Health Care Insurance Plan Taskforce Meeting

Assessment of Arizona Health Care Coverage

Howard J. Eng, Dr. P.H.

Southwest Border Rural Health Research Center
Rural Health Office
College of Public Health
University of Arizona
Tucson, Arizona

December 11, 2001

Assessment Commissioned by AHCCCS Funded by HRSA State Planning Grant

Assessment Team

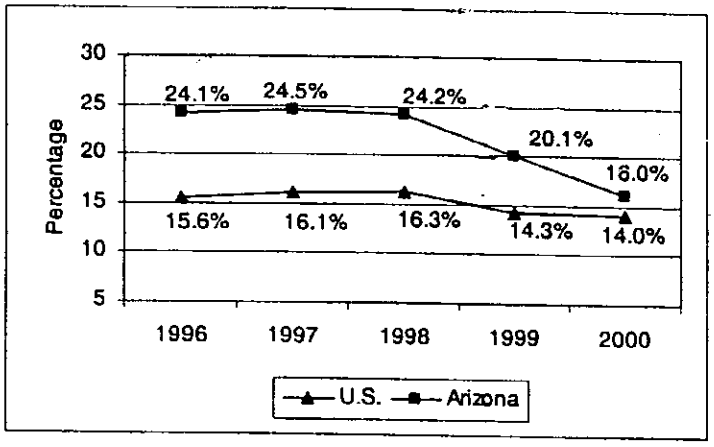
RHO Staff

Howard J. Eng
Eva Paz-Ono
Michael Voloudakis
Cindy Resnick
Michelle Parcés
Ishrat Khandokar
Julie Jacobs
Merissa Winnicki

Consultants

Merlin DuVal
Karl Yordy
Ronald Vogel
Joel Brill

U. S. and Arizona Uninsured Population Estimates: 1996-2000*



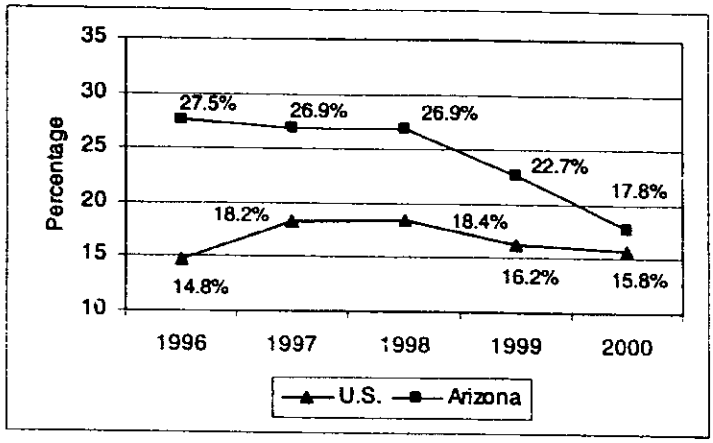
Source: U. S. Census Bureau: Health Insurance Historical Table 4
*U.S. Census revised figures for 1999 and 2000

Table 1. Uninsured Ranking for All Ages: Top 15 States

Rank	2000	1999	1998	1997	1996
U.S.	14.0%	14.3%	16.3%	16.1%	15.6%
1	New Mexico	New Mexico	Texas	Arizona/Texas (24.5%)	Texas
2	Texas	Texas	Arizona (24.1%)		Arizona (24.1%)
3	Alaska	Louisiana	California	Arkansas	New Mexico
4	Oklahoma	Arizona (20.1%)	Nevada	New Mexico	Arkansas
5	Louisiana	California	New Mexico	California	Louisiana
6	Montana	Alaska	Mississippi	Mississippi	California
7	California	Nevada	Montana	Florida	Florida
8	Florida	Idaho	Louisiana	Montana	Mississippi
9	Arizona (16.0%)	Florida	Arkansas	Louisiana	Georgia
10	Nevada	Montana	Oklahoma	Alaska	South Carolina
11	Idaho	Oklahoma	Idaho	Idaho Oklahoma	New York Oklahoma
12	New York	Mississippi West Virginia South Carolina	Florida Georgia	*	New Jersey
13	Georgia Wyoming	*	*	Georgia	Idaho
14	*	*	Alaska	Nevada New York	North Carolina
15	West Virginia	Colorado	New York	*	*

Source: U. S. Census Bureau: Health Insurance Historical Table 4. Note: Census Revised Numbers for 1999 and 2000.
*Blanks are due to states tied for a ranking.

U. S. and Arizona Uninsured Under 65 Population Estimates: 1996-2000*



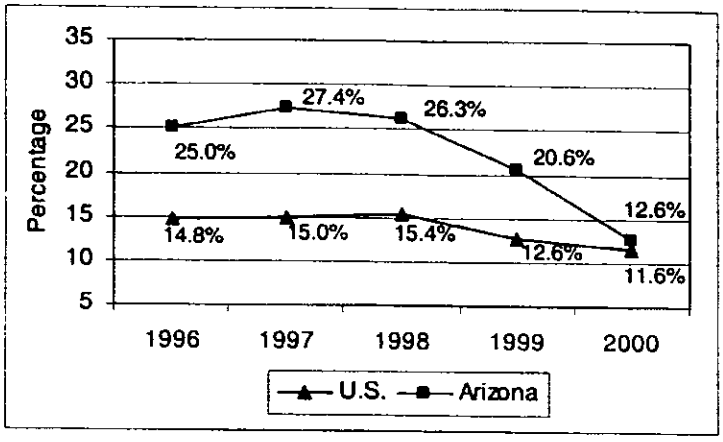
Source: U. S. Census Bureau: Health Insurance Historical Table 6
*U.S. Census revised figures for 1999 and 2000

Table 2. Uninsured Ranking for Under Age 65: Top 15 States

Rank	2000	1999	1998	1997	1996
U.S.	15.8%	16.2%	18.4%	18.2%	14.8%
1	New Mexico	New Mexico	Arizona/Texas (26.9%)	Arizona (26.9%)	Arizona (27.5%)
2	Texas	Texas	*	Texas	Texas
3	Oklahoma	Louisiana	California	New Mexico	Arkansas
4	Louisiana	Arizona (22.7%)	New Mexico	California	New Mexico
5	Montana	Florida	Nevada	Florida	Louisiana
6	Florida	California	Mississippi	Mississippi	Florida
7	Alaska	Idaho	Montana	Louisiana Montana	California
8	California	Nevada	Arkansas	*	Mississippi
9	Nevada	Montana	Louisiana	Arkansas	Georgia Oklahoma
10	Arizona (17.8%)	Alaska	Oklahoma	Oklahoma	*
11	Idaho	Oklahoma	Florida	New York	New Jersey New York
12	New York	West Virginia	West Virginia	Idaho Nevada	*
13	West Virginia	South Carolina	Idaho New York	*	South Carolina
14	Wyoming	Mississippi	*	Georgia	Idaho
15	Oregon Arkansas	New York	Alabama	Alaska	North Carolina

Source: U. S. Census Bureau: Health Insurance Historical Table 6. Note: Census Revised Numbers for 1999 and 2000.
*Blanks are due to states tied for a ranking.

U. S. and Arizona Uninsured Under 18 Population Estimates: 1996-2000*



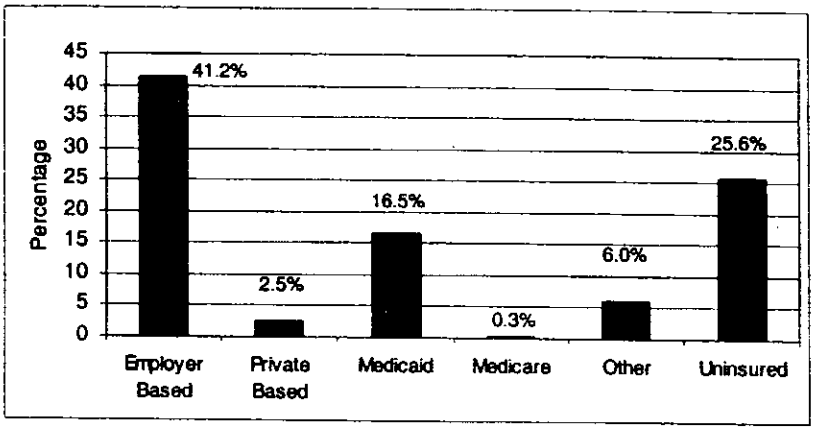
Source: U. S. Census Bureau: Health Insurance Historical Table 5
*U.S. Census revised figures for 1999 and 2000

Table 3. Uninsured Ranking for Under Age 18: Top 15 States

Rank	2000	1999	1998	1997	1996
U.S.	11.6%	12.6%	15.4%	15.0%	14.8%
1	Texas/New Mexico	New Mexico	Arizona (26.3%)	Arizona/Arkansas (24.5%)	Arizona (25.8%)
2		Louisiana	Texas		Texas
3	Montana	Texas	Nevada	Texas	Louisiana
4	Alaska	Arizona (20.6%)	Oklahoma	Louisiana	Arkansas/South Carolina
5	Oklahoma	Idaho	Mississippi	Florida	
6	Florida	Nevada	California	New Mexico	Oklahoma
7	Louisiana	Montana	Montana	Nevada	Nevada
8	California	South Carolina	Georgia	Mississippi	Tennessee
9	Nevada	California	Arkansas	Idaho	New Jersey
10	Idaho	Oklahoma	Louisiana	California/South Carolina	Colorado/ Florida/ Mississippi
11	Colorado	Alaska	Florida		
12	Indiana	Florida	Alabama	Montana/North Carolina	
13	Oregon		Delaware/Idaho		California
14	Arizona (12.6%)	Mississippi		North Dakota	New Mexico
15	Wyoming	Wyoming	Maryland	Georgia/ Oklahoma	Kentucky

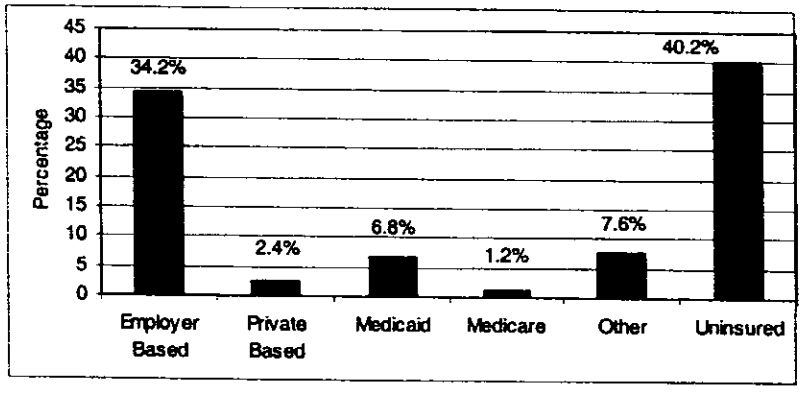
Source: U. S. Census Bureau: Health Insurance Historical Table 6. Note: Census Revised Numbers for 1999 and 2000.
*Blanks are due to states tied for a ranking.

Arizona 0-17 Age Group Breakdown of Health Care Coverage



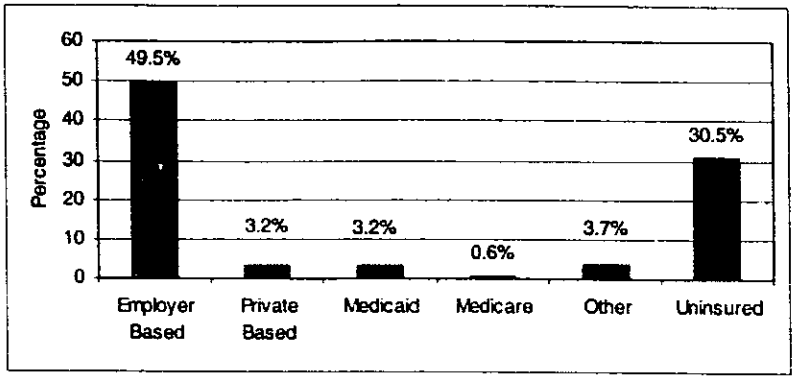
Source: U. S. Census Bureau: 1999 Current Population Survey, Arizona Sample

Arizona 18-24 Age Group Breakdown of Health Care Coverage



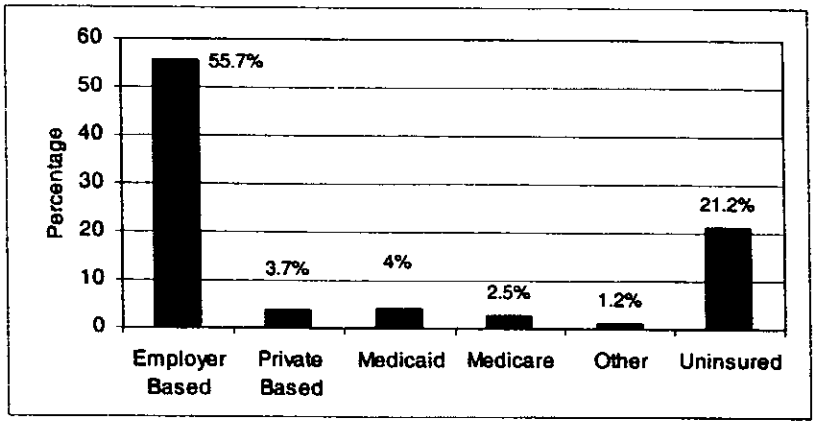
Source: U. S. Census Bureau: 1999 Current Population Survey, Arizona Sample

Arizona 25-34 Age Group Breakdown of Health Care Coverage



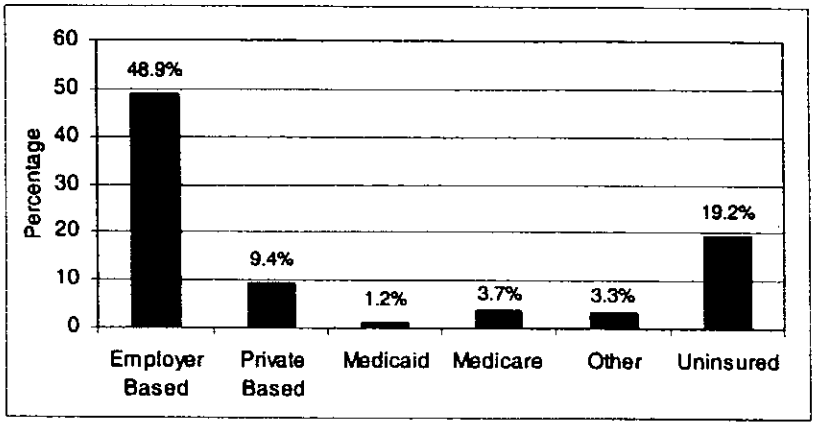
Source: U. S. Census Bureau: 1999 Current Population Survey, Arizona Sample

Arizona 35-44 Age Group Breakdown of Health Care Coverage



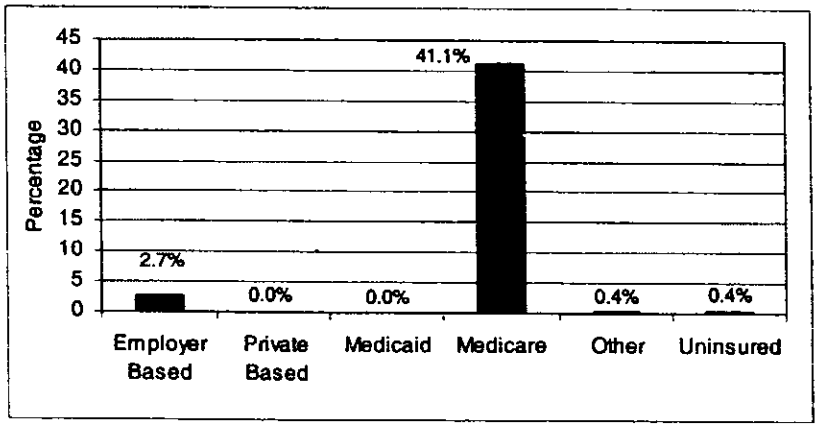
Source: U. S. Census Bureau: 1999 Current Population Survey, Arizona Sample

Arizona 45-64 Age Group Breakdown of Health Care Coverage



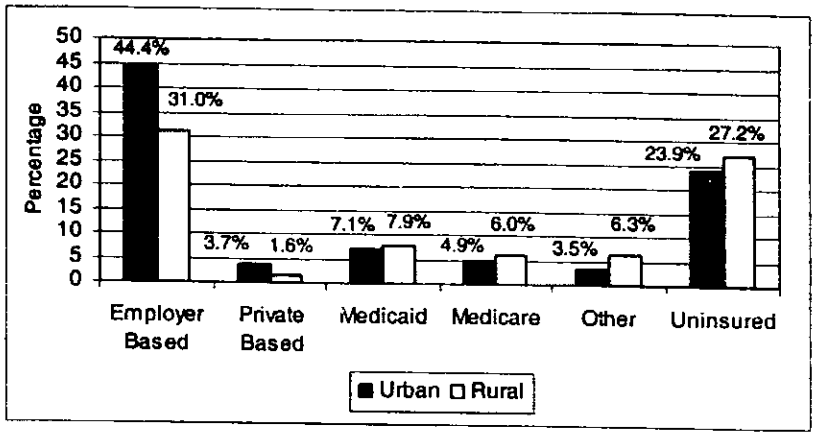
Source: U. S. Census Bureau: 1999 Current Population Survey, Arizona Sample

Arizona 65+ Age Group Breakdown of Health Care Coverage



Source: U. S. Census Bureau: 1999 Current Population Survey, Arizona Sample

Arizona Rural versus Urban Breakdown of Individuals with Selected Health Care Coverage



Source: U. S. Census Bureau: 1999 Current Population Survey, Arizona Sample

REFERENCE TITLE: health care system task force

State of Arizona
House of Representatives
Forty-fifth Legislature
Second Regular Session
2002

H. B. _____

Introduced by _____

AN ACT

ESTABLISHING THE STATEWIDE HEALTH CARE SYSTEM TASK FORCE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Statewide health care system task force

A. The statewide health care system task force is established consisting of the following members:

1. Four members of the house of representatives who are appointed by the speaker of the house of representatives, not more than two of whom are members of the same political party. The speaker of the house of representatives shall designate one of the members as cochairperson of the task force.

2. Four members of the senate who are appointed by the president of the senate, not more than two of whom are members of the same political party. The president of the senate shall designate one of the members as cochairperson of the task force.

3. One member who is a health care provider, who is licensed in this state and who is appointed by the governor.

4. One member who represents a consumer advocacy group and who is appointed by the governor.

5. One member who represents the business community and who is appointed by the governor.

6. One member who represents the university of Arizona health science center.

B. The task force shall:

1. Be guided by the principle that health care should be:

(a) Available and accessible.

(b) Affordable and properly financed.

(c) Provided through a seamless system.

(d) Done in collaboration and in cooperation with the various stakeholders from the public and private sector.

2. Continue the efforts of the statewide health care insurance plan task force and develop and implement the statewide health care insurance plan as set forth in its December, 2001 report.

3. Make recommendations to narrow the gap between existing public and private health coverage programs by further examining the feasibility of implementing:

(a) Insurance reform to promote more accessible and affordable coverage options, especially those targeted at the individual and small group markets, such as the healthcare group programs established pursuant to section 36-2912, Arizona Revised Statutes.

(b) A consumer and employer education initiative on the value of health care coverage and the existing options for the uninsured within the private marketplace.

(c) Private-public coverage programs such as a high risk pool, a full cost buy-in program or premium assistance employer buy-in program.

(d) A program to encourage employers with one hundred or fewer employees to cooperatively purchase employee health care benefits from new or existing insurance programs, including the Arizona health care cost containment system.

4. Make recommendations regarding restructuring the current state employee and retiree health care coverage program to improve access and affordability by continuing to evaluate various options including a self-insurance system and an expansion of pool size.

5. Make recommendations to enhance existing public supported programs through:

(a) Support of effective outreach programs targeted to enroll eligible uninsured persons.

(b) Pending federal approval, coverage of title XXI parents with family income of up to two hundred per cent of the federal poverty guidelines.

(c) Identification of title XIX coverage groups that could be expanded through a state plan amendment and development of a plan for implementation of coverage groups selected for expansion.

6. Actively engage in a partnership for the statewide health program with the federal centers for medicare and medicaid services.

7. Identify ways to improve the rural health care infrastructure by:

(a) Continuing to support safety net providers.

(b) Fostering volunteerism and engaging the services of retirees from the health care professions.

(c) Encouraging competition between health care service providers.

(d) Increasing accessibility to medical services through:

(i) Medical student residency rotations.

(ii) Faculty rotations in medical practices that allow physicians to participate in miniresidencies and training programs.

(iii) Tracking residency programs and where medical school graduates locate to practice medicine.

(e) Developing a plan to more effectively coordinate current rural health care resources and programs through a rural health network that includes the following:

(i) Loan repayment programs.

(ii) Scholarship, grant, career education and primary care programs.

(iii) An emergency medical services network.

(iv) Emergency interdisciplinary training.

(v) A telemedicine network.

(vi) Continuing education programs.

(vii) Outreach and promotion of public and private health care services.

(viii) Capital project grants.

(ix) Health service districts.

(x) A critical access hospital program.

(xi) Community health centers.

(xii) Mobile clinics.

C. Task force members are not eligible for compensation or for reimbursement of expenses.

D. On or before November 15 of each year, the task force shall submit a written proposal for implementing the statewide health care system plan and any findings and recommendations regarding the plan to the governor, the speaker of the house of representatives and the president of the senate and shall provide a copy of this proposal to the secretary of state and the director of the Arizona state library, archives and public records.

Sec. 2. Delayed repeal

This act is repealed from and after December 31, 2004.